nrhi Network for Regional Healthcare Improvement

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

# ACHIEVING HIGHER VALUE HEALTH CARE IN ALASKA: How Local Leadership Can Control Costs & Improve Quality

**Harold D. Miller**
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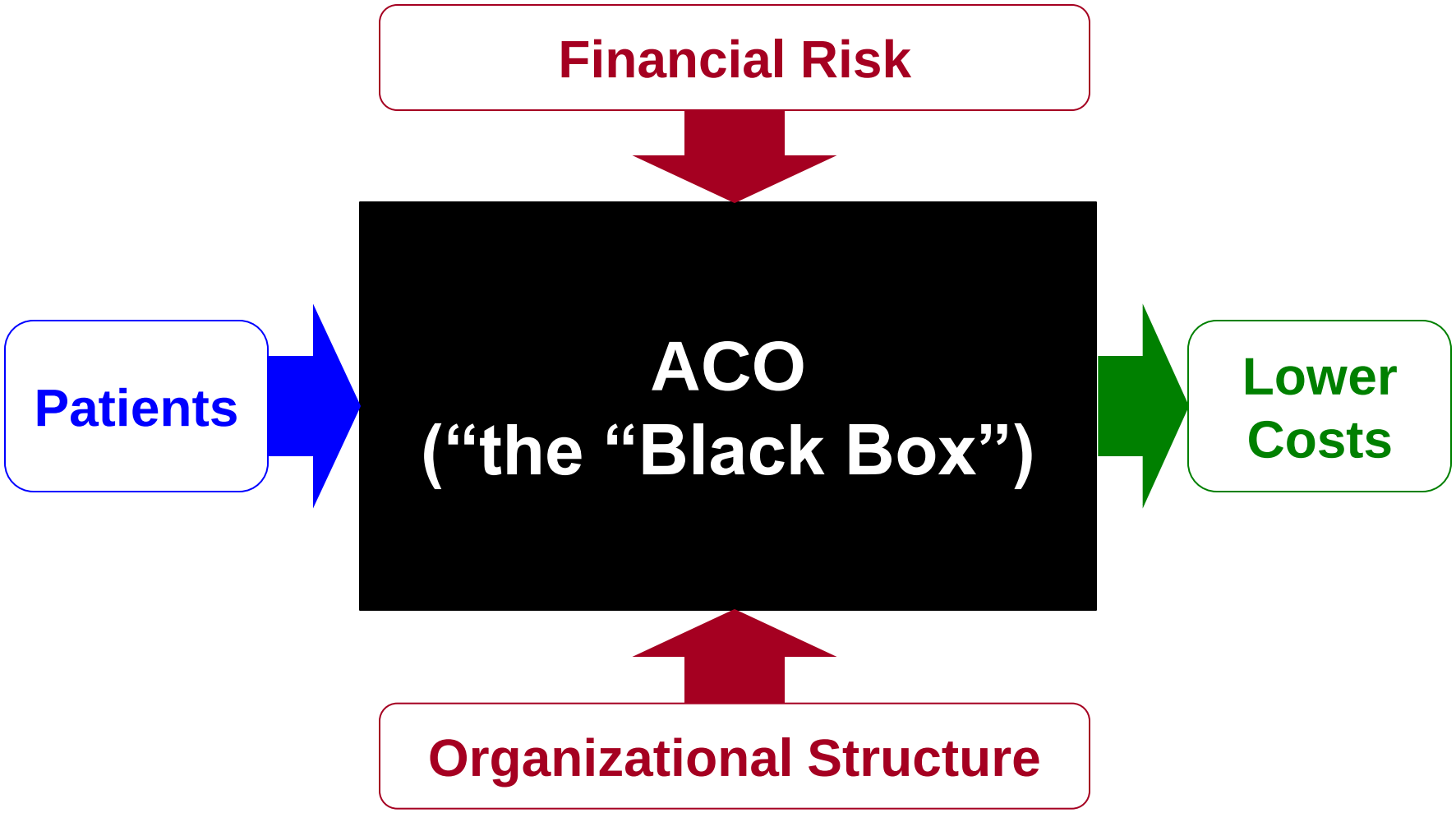
**Network for Regional Healthcare Improvement**
**and**
**Executive Director**
**Center for Healthcare Quality and Payment Reform**

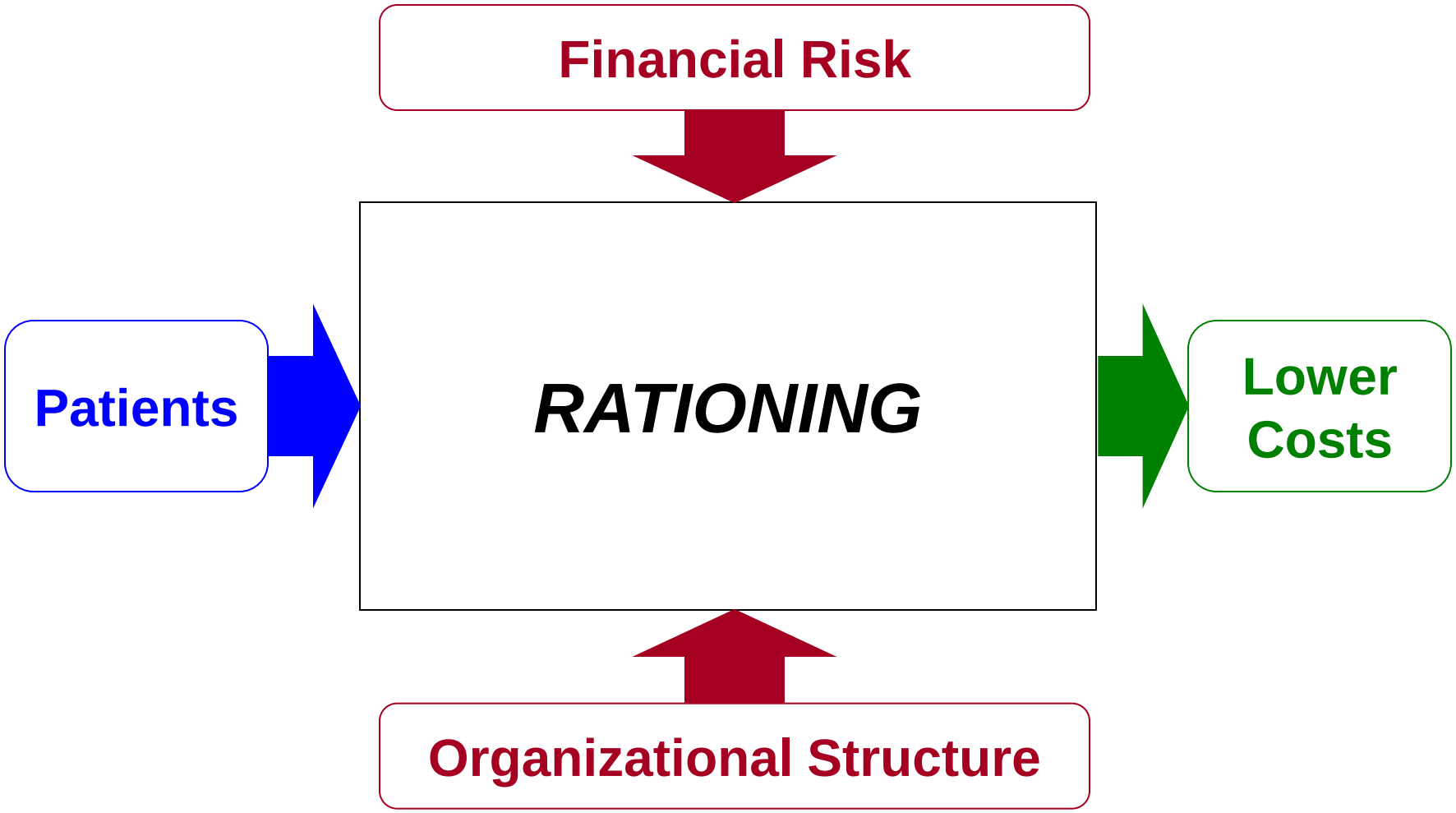
# Are ACOs the Answer to Higher-Value Health Care?

# Everyone Is Focusing On “Risk” and Organizational Structure

# But How Will ACOs Generate All These Savings?



# What's In That Black Box Can't Be Good For Consumers, Can It?

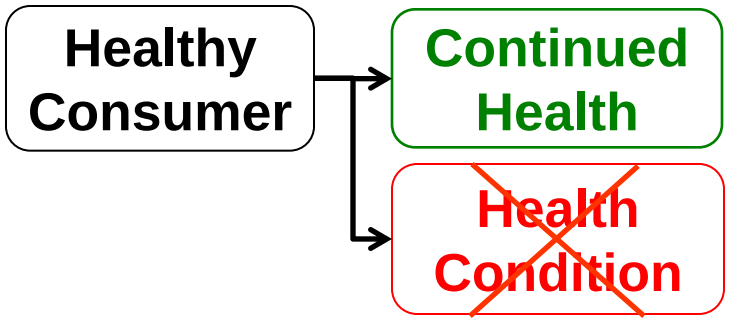


# Our Focus Should Be On How to Reduce Costs Without Rationing

# Reducing Costs Without Rationing: ***Can It Be Done??***

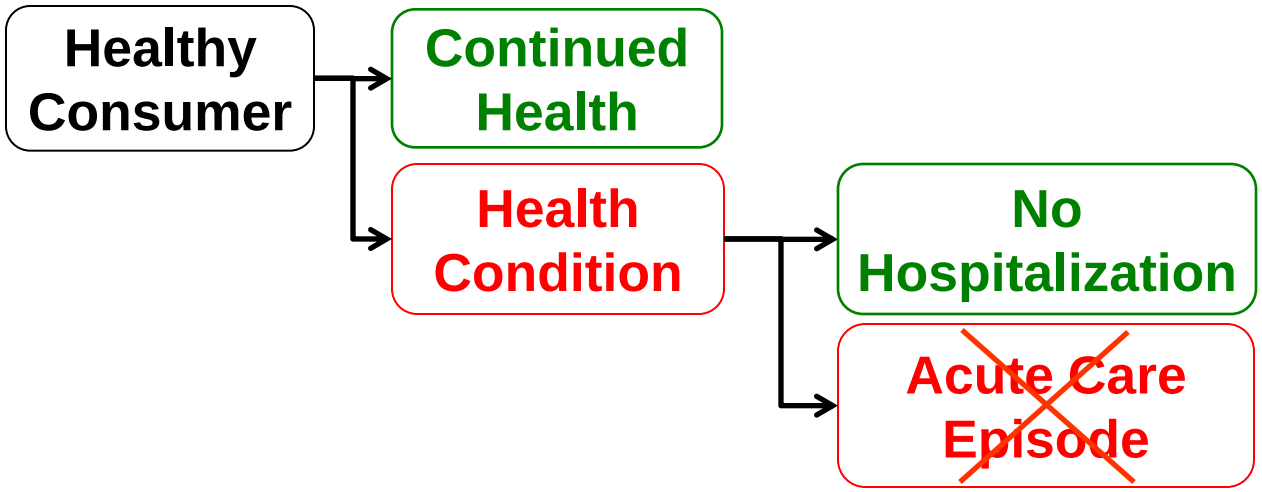
# Reducing Costs Without Rationing:

## Prevention and Wellness

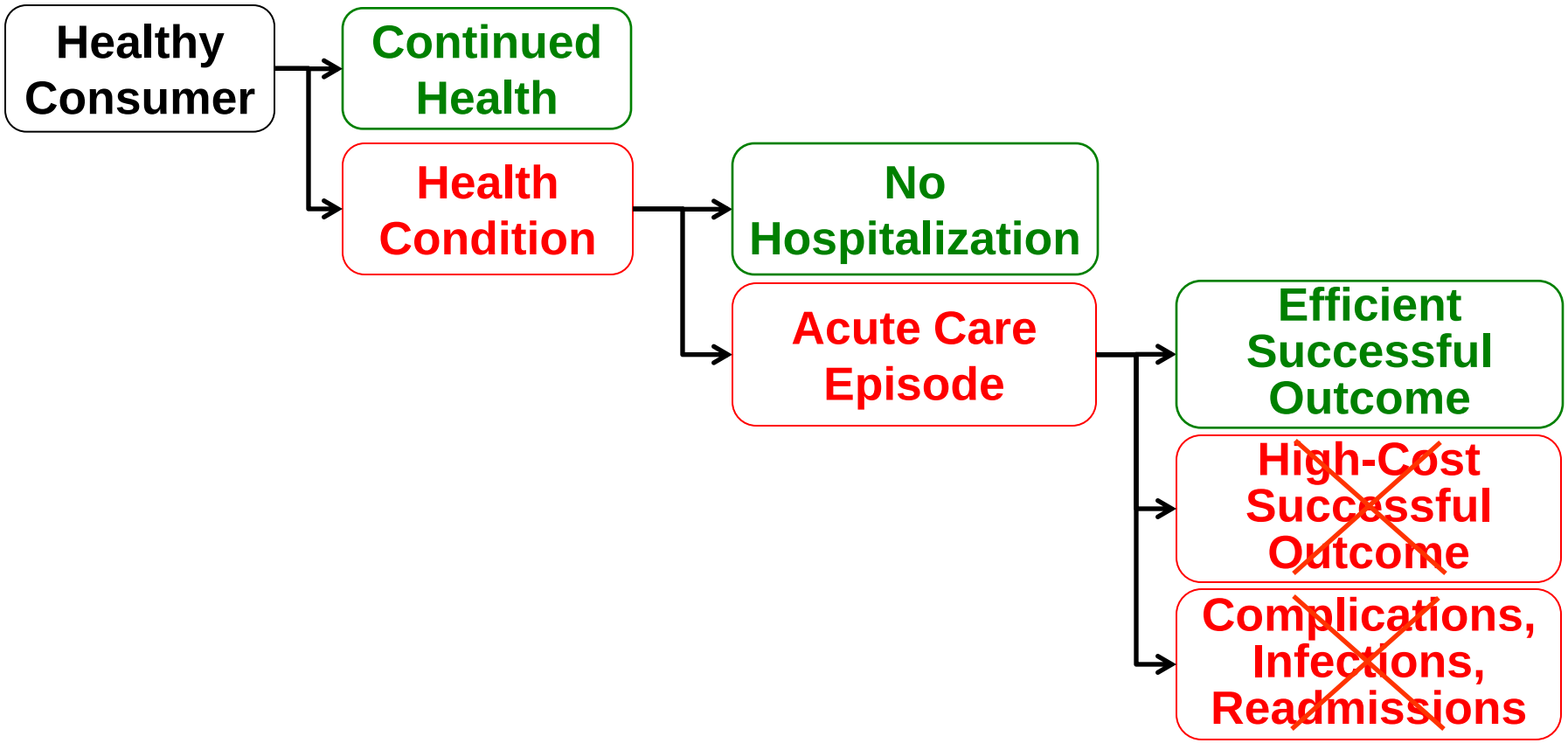


# Reducing Costs Without Rationing:

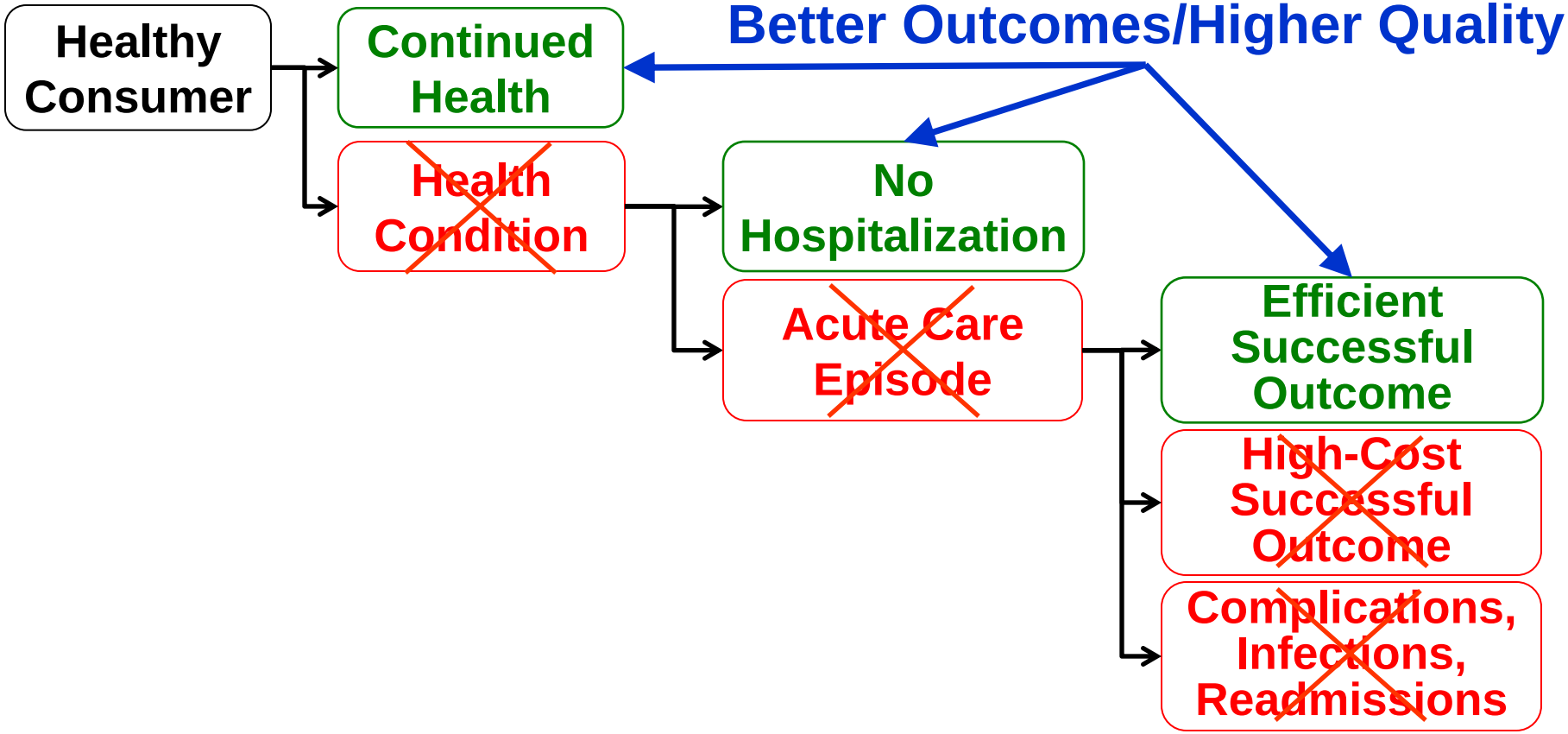
## Avoiding Hospitalizations



# Reducing Costs Without Rationing: Efficient, Successful Treatment



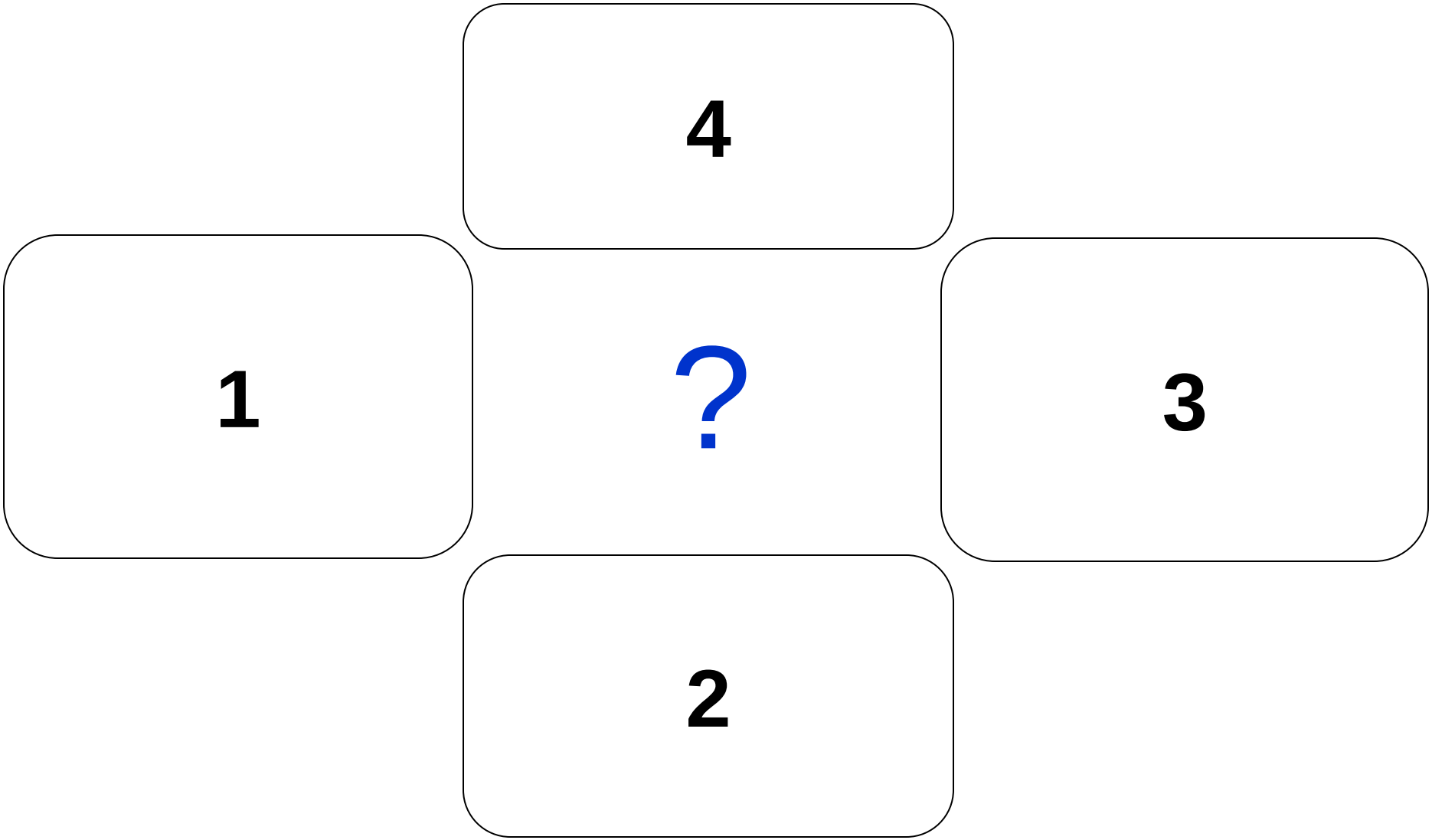
# Reducing Costs Without Rationing Is Also Quality Improvement!



# Reducing Costs Without Rationing Can't Be Done from Washington...

# ...It Has to Happen at the Local Level, Where Health Care is Delivered.

# Functions Needed for Regional Healthcare Reform



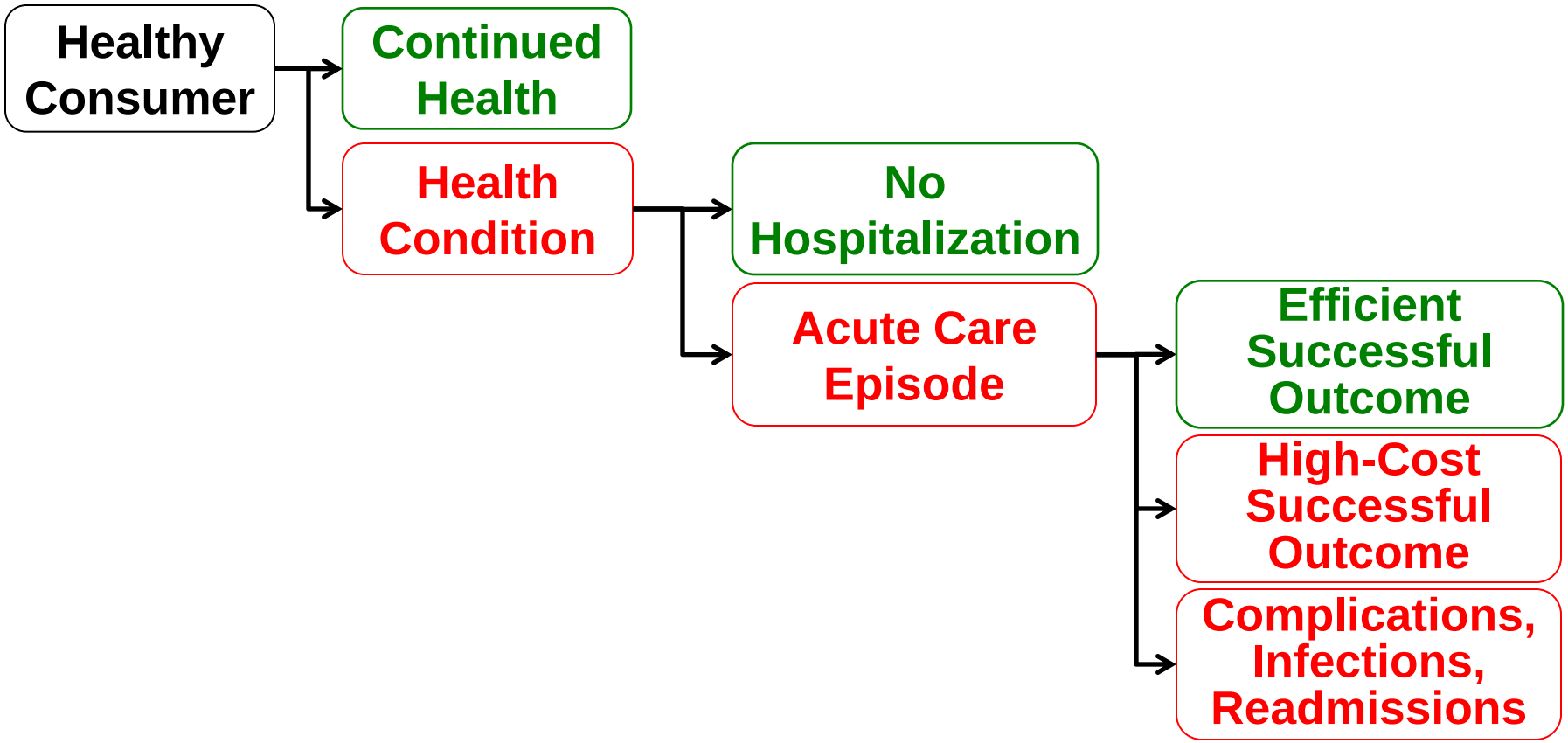
# Lack of Actionable Information About Utilization/Costs

- Barrier:
  - Most physician practices don't know if they have high rates of preventable hospitalizations, complications, etc.
  - PCPs typically don't even know if their patients go to the ER or are hospitalized
  - Prices of facilities and treatments are secret or impossible to compare

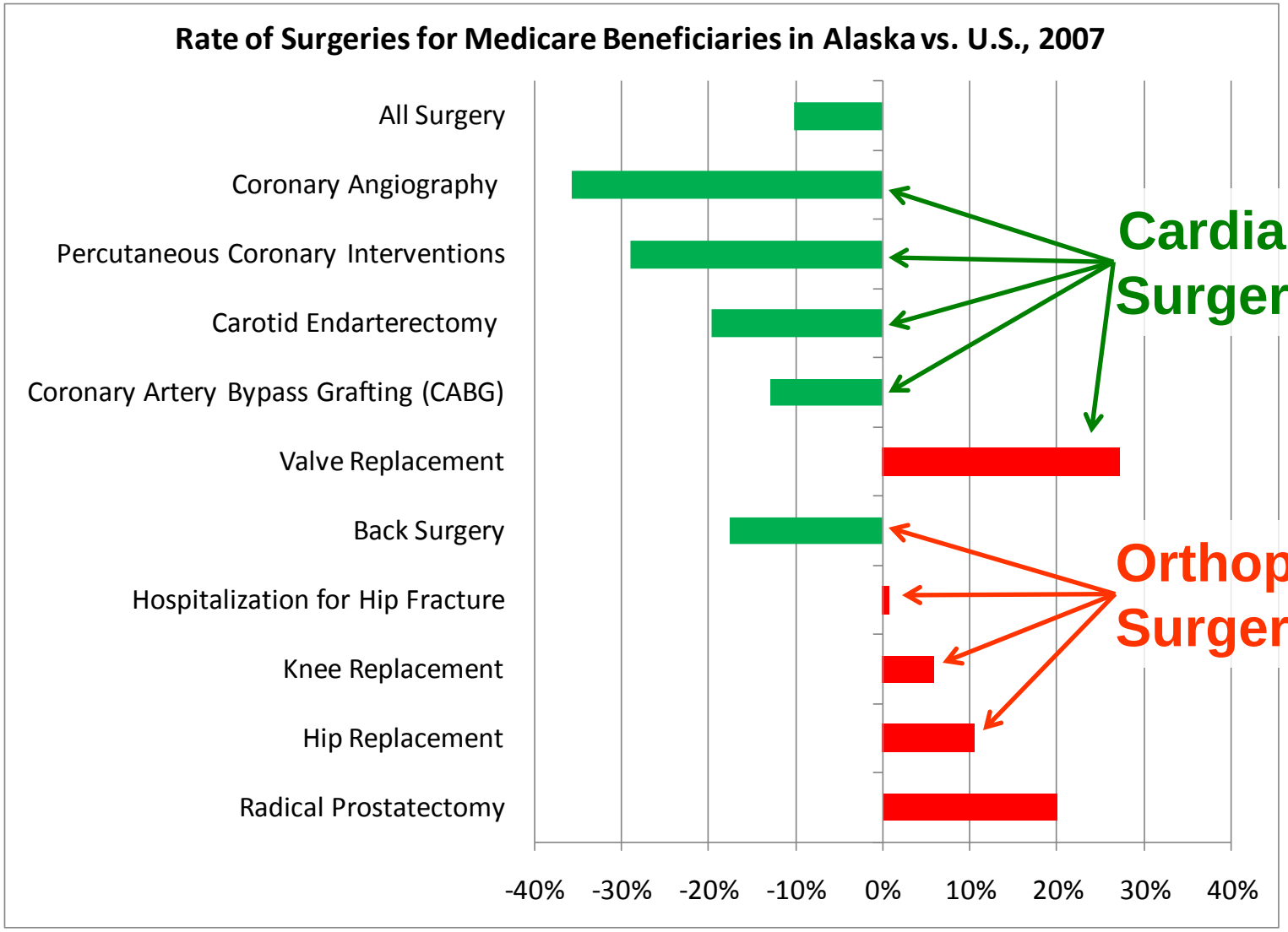
# Turn Reams of Data Into *Timely, Useable Information*

- Barrier:
  - Most physician practices don't know if they have high rates of preventable hospitalizations, complications, etc.
  - PCPs typically don't even know if their patients go to the ER or are hospitalized
  - Prices of facilities and treatments are secret or impossible to compare
- Solution:
  - Analyze data to help physicians find opportunities for cost savings & quality improvement
  - Provide real-time performance measurement to support continuous quality improvement

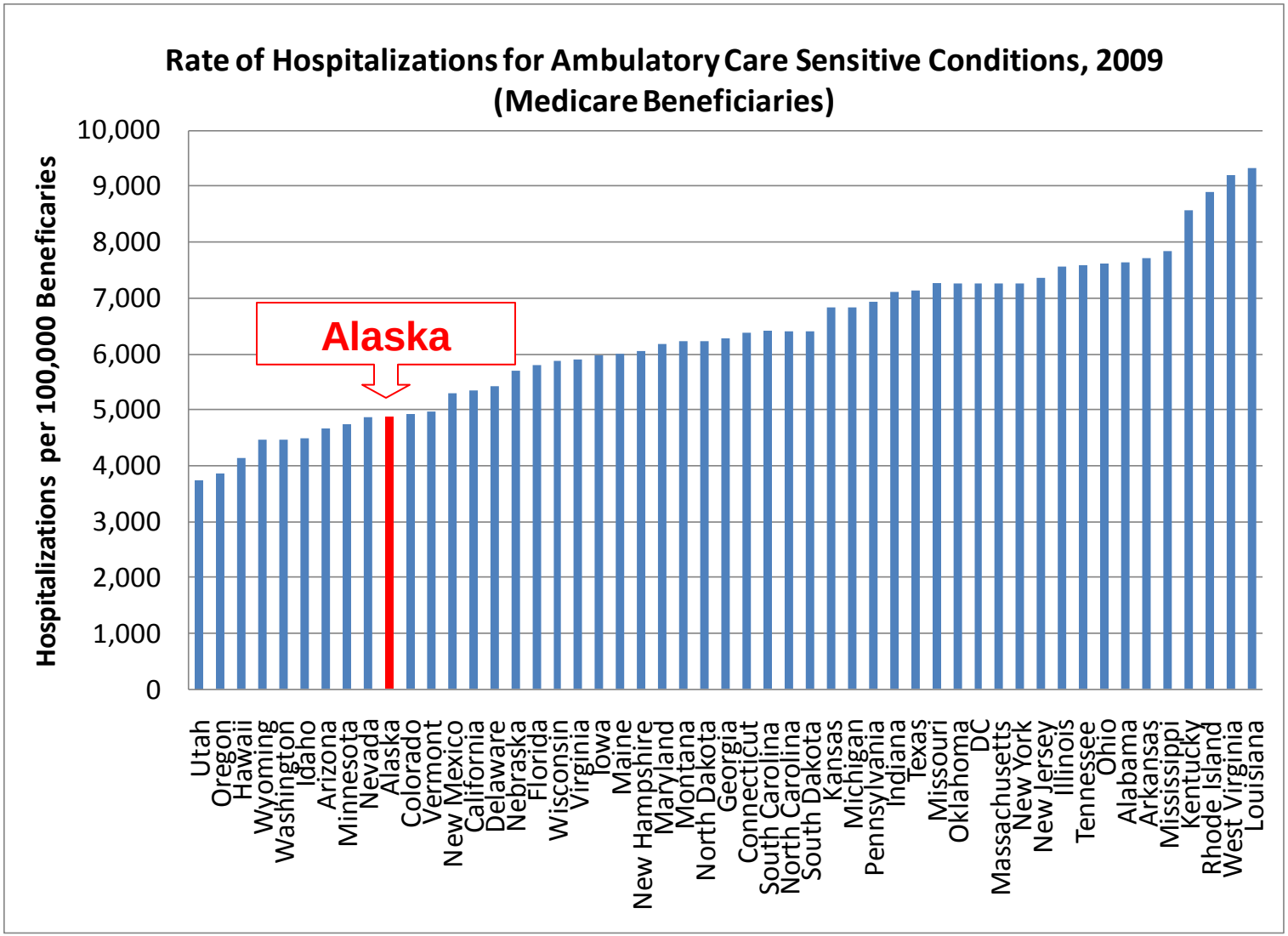
# How Is Alaska Doing?



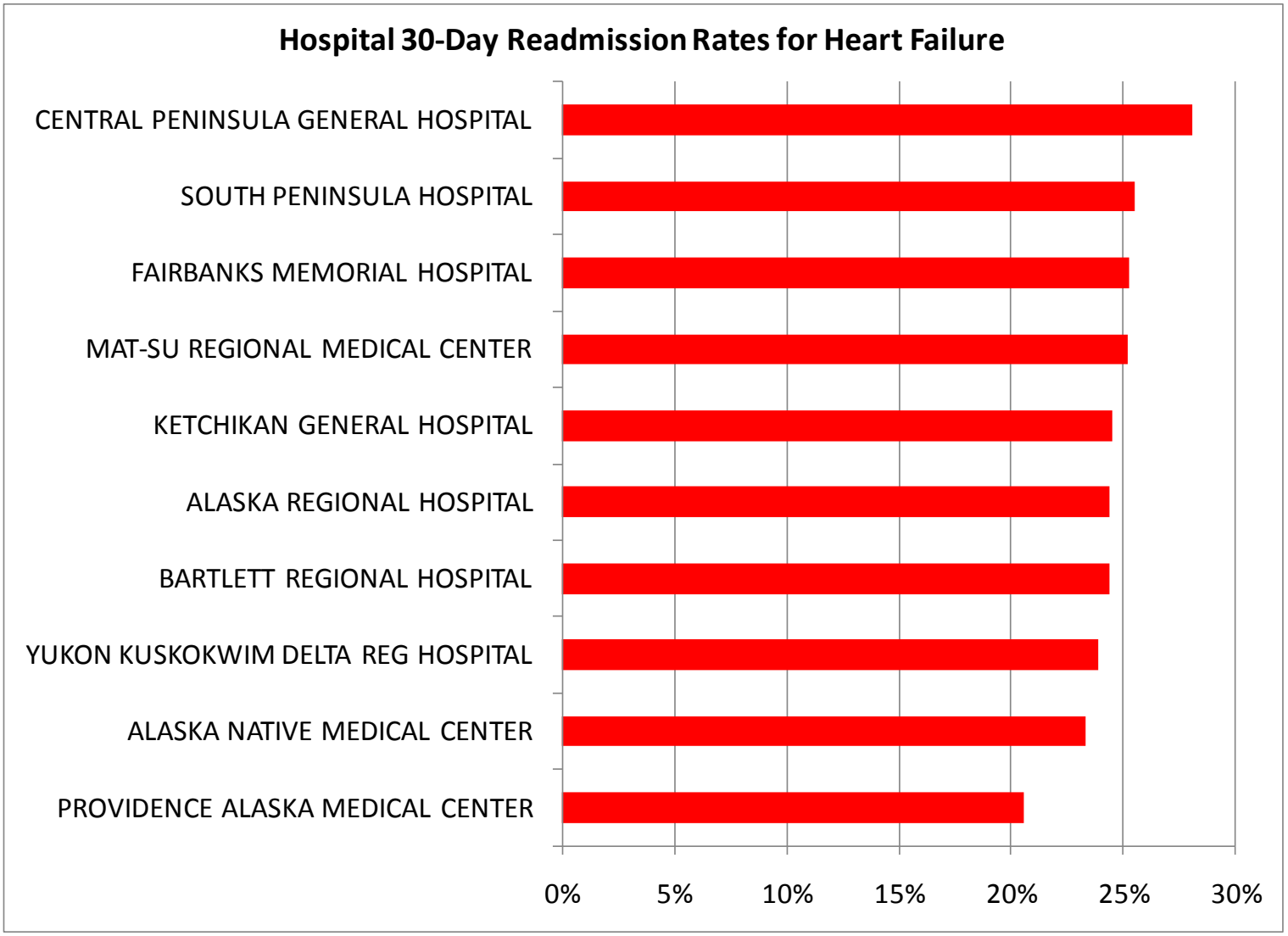
# Better Hearts and Worse Joints in Alaska Than Other States?



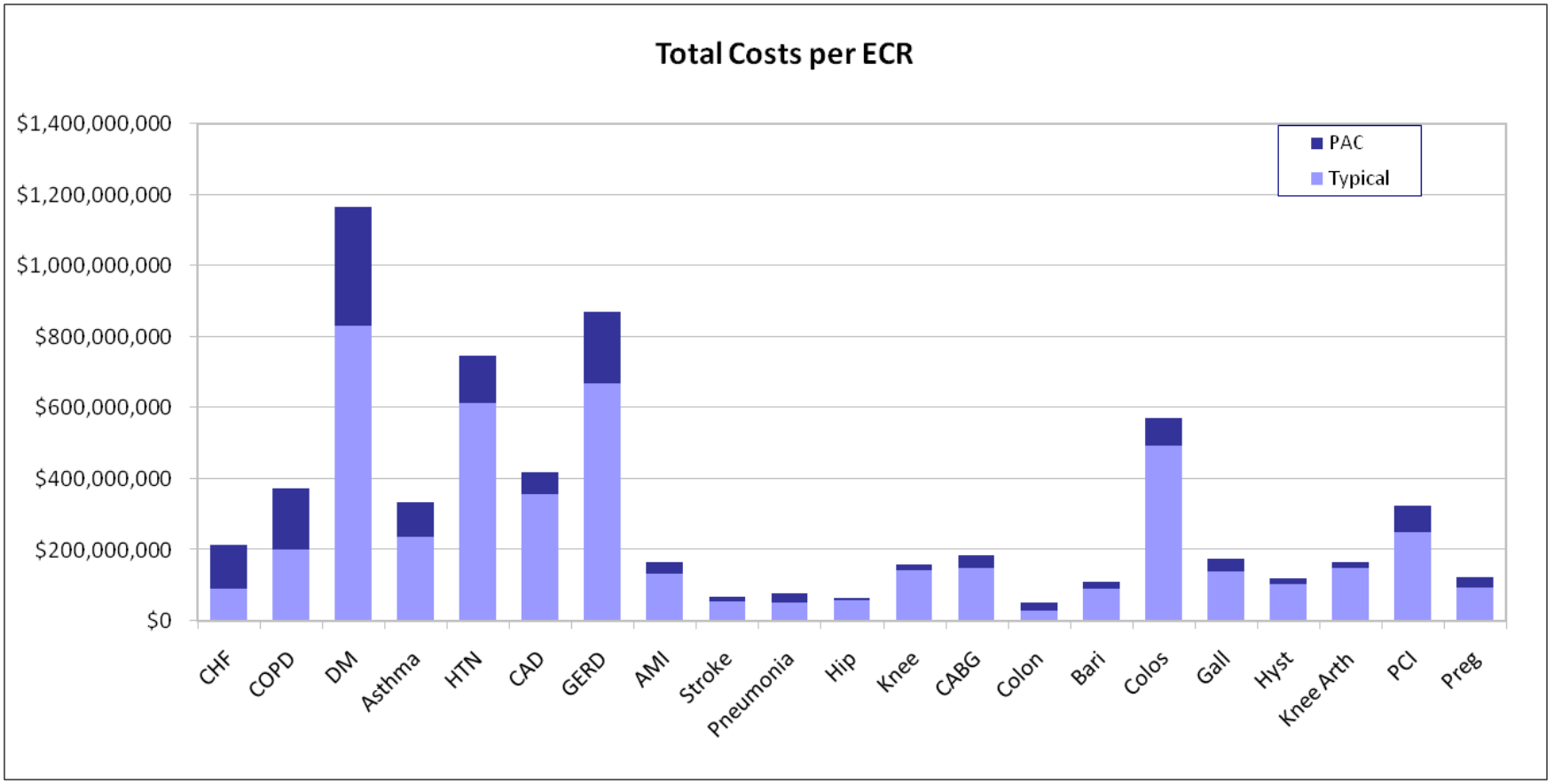
# Low Preventable Admission Rate in Alaska, But Room to Improve



# 25% of CHF Patients Return to The Hospital Within One Month



# Example: Prometheus Analyses of Avoidable Complications

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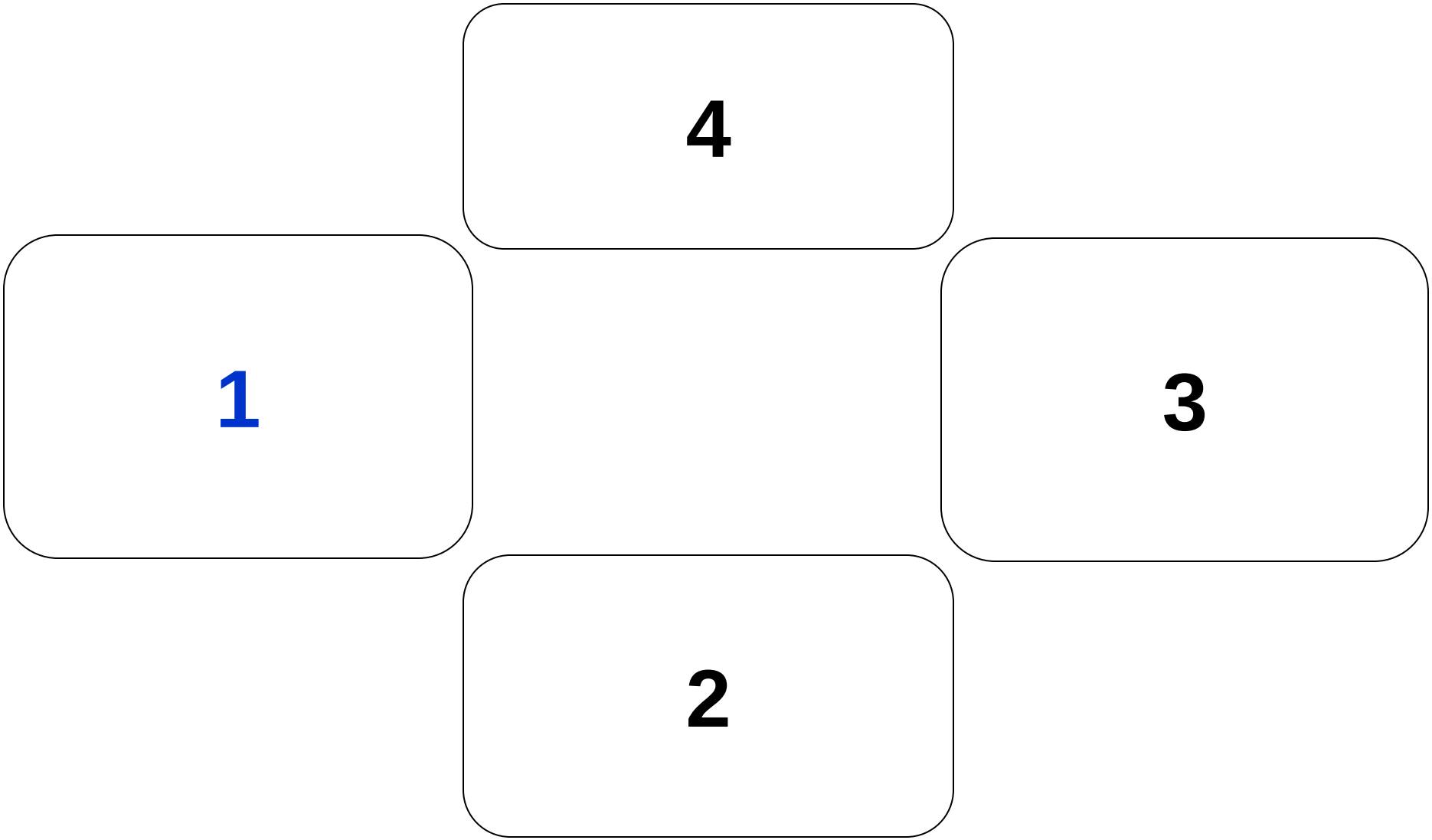
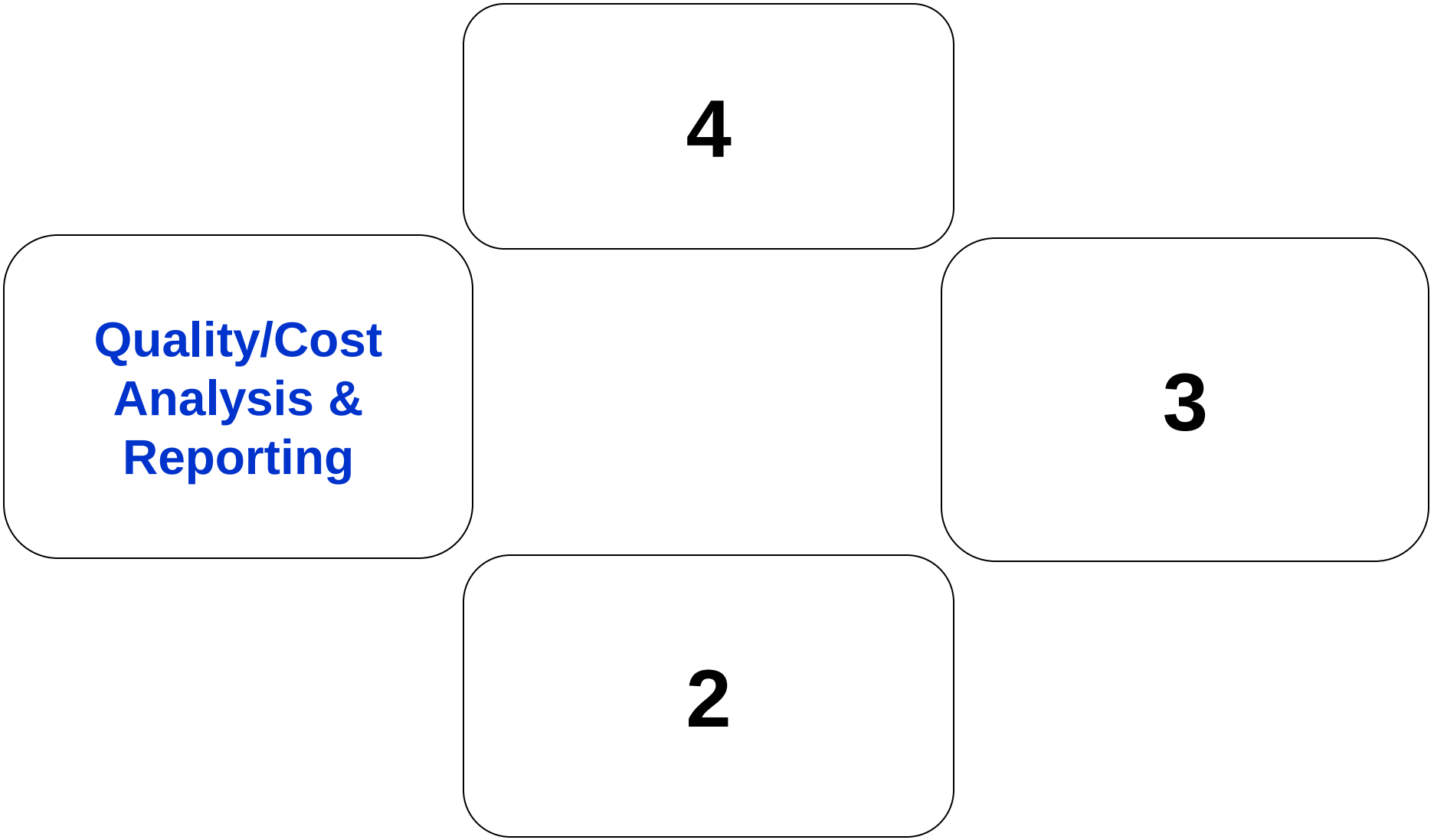
# Functions Needed for Regional Healthcare Reform



# Analysis & Reporting is #1



# “Measurement” vs. “Analysis”

- *Measurement* presumes we know what we’re looking for, that we know what’s desirable/achievable in all communities, and that we can legitimately rate/rank providers based on the measures
  - That’s a high standard, and it’s not surprising that we don’t have adequate measures in many important areas, particularly outcome measures

# “Measurement” vs. “Analysis”

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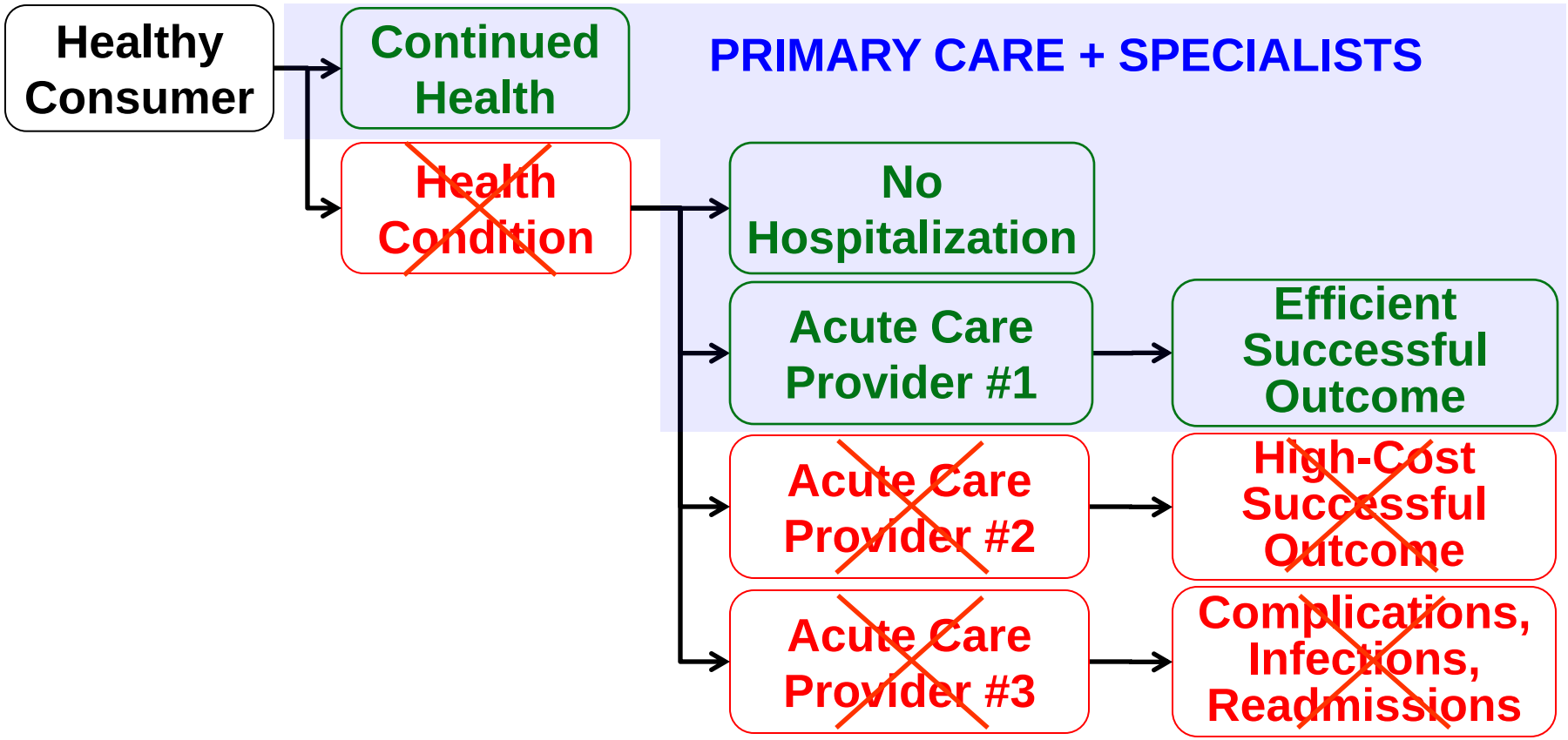
  - That’s a high standard, and it’s not surprising that we don’t have adequate measures in many important areas, particularly outcome measures
- *Analysis*, particularly *exploratory* analysis, presumes only that we believe there are opportunities to improve value, and that more work will be needed to determine what is achievable and cost-effective

# Who Should Be Accountable For Achieving Higher Value Care?

- Health Plans?
- Hospitals?

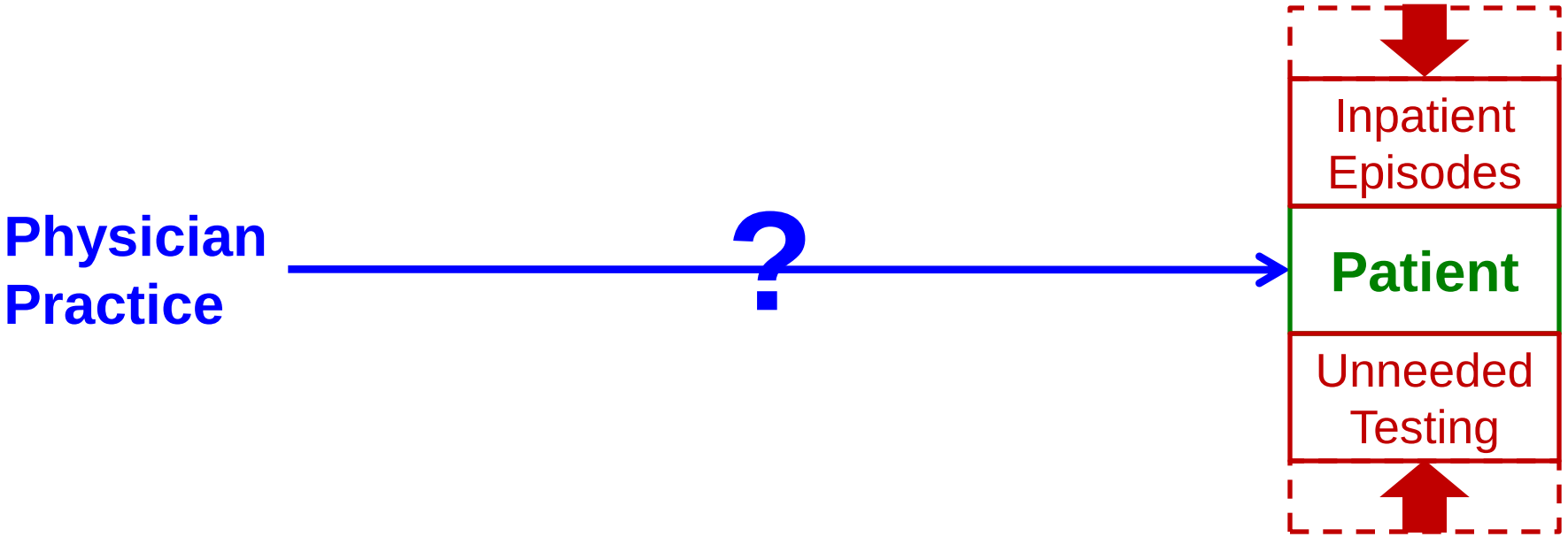
# *Physicians* are at the Core of "Accountable Care"



# Accountability Requires New and Improved Skills & Relationships

1. Physicians will need to develop/expand skills in reducing preventable hospitalizations, unnecessary testing, etc.
2. Primary care physicians and (multiple) specialists will need to work together to better manage complex cases
3. Physicians and hospitals will need to work together to improve quality and lower costs for inpatient care

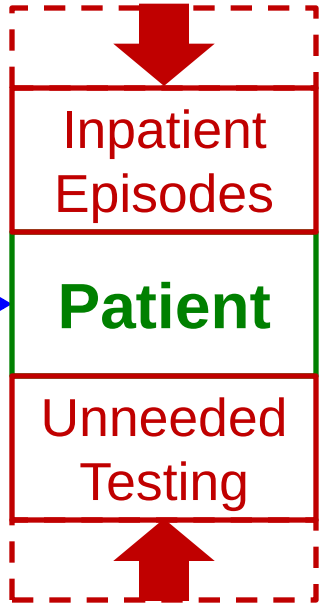
# What Skills Do Physicians Need to Take Accountability?



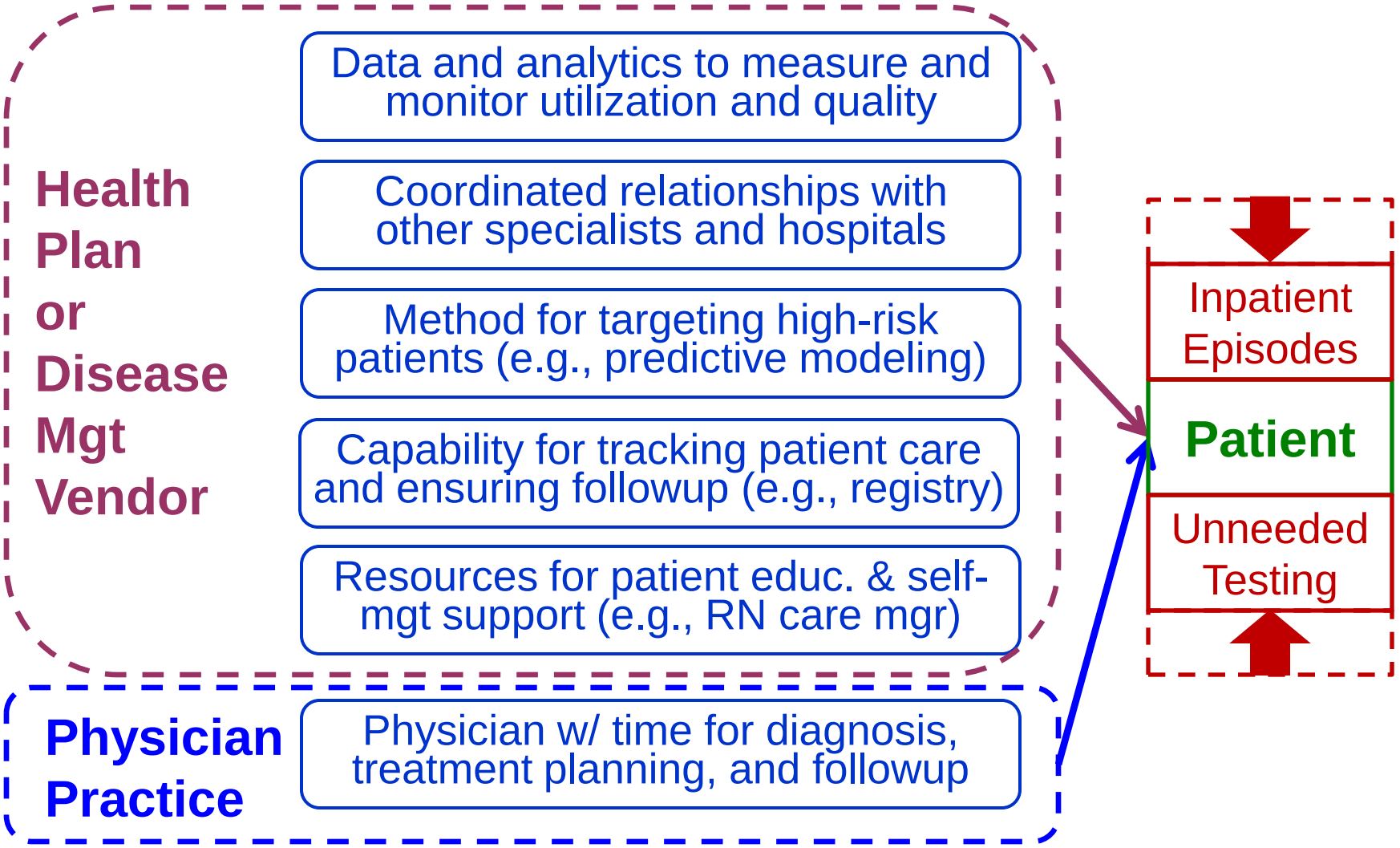
# Resources/Capabilities Needed for MDs to Take Accountability

**Physician Practice**

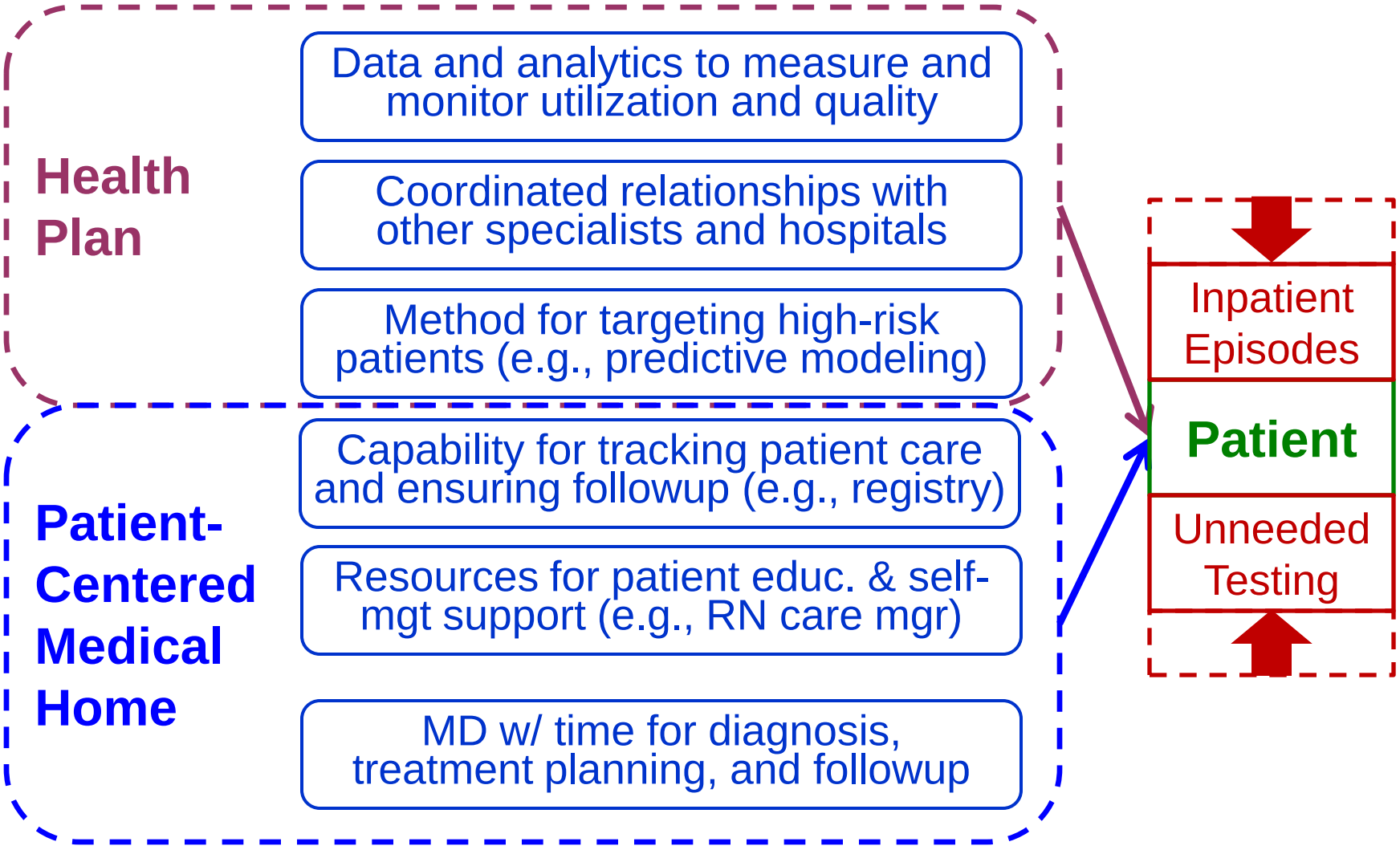
- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with other specialists and hospitals
- Method for targeting high-risk patients (e.g., predictive modeling)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- MD w/ time for diagnosis, treatment planning, and followup



# Capabilities Exist Today, But Don't Coordinate w/ Physicians



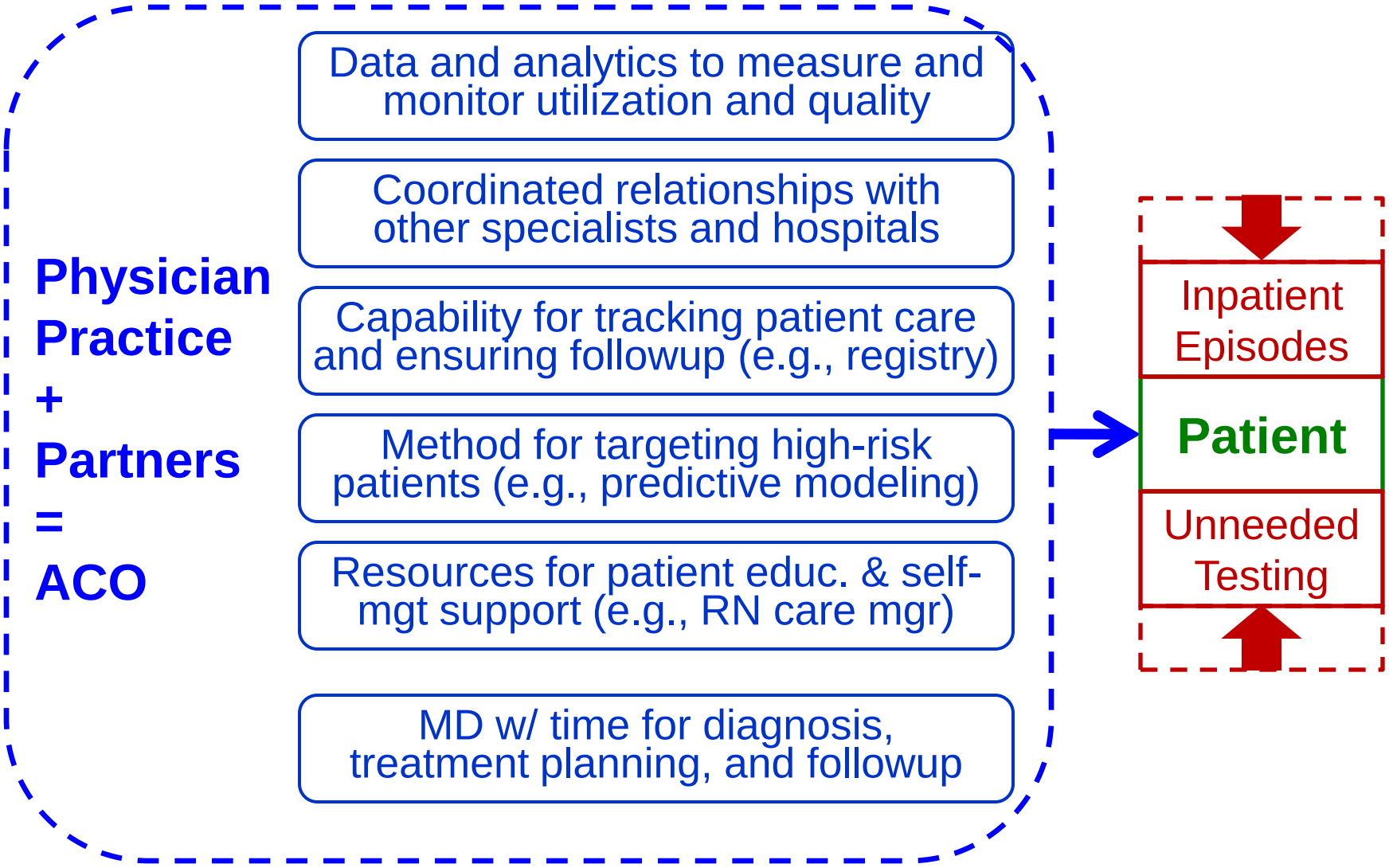
# Medical Home Initiatives Expand MD Capacity, But Not Enough



# Global/Episode Payment Requires ROI Analysis & Targeting

- **Return on Investment (ROI; Cost-Effectiveness)**
  - Cost of intervention
    vs.
  - Savings from reduced utilization
- **Timeframe for Return**
  - Short-term: readmission, ER reduction, complex patients
  - Long-term: prevention, early-stage chronic disease patients
- **Targeting Services/Patient Segmentation**
  - Focusing additional services on high-utilization patients
    vs.
  - Providing services to all patients as a general “benefit”

# Goal: Give MDs the Capacity to Deliver "Accountable Care"



# #2 Is Redesigning Care for Better Outcomes & More Efficiency

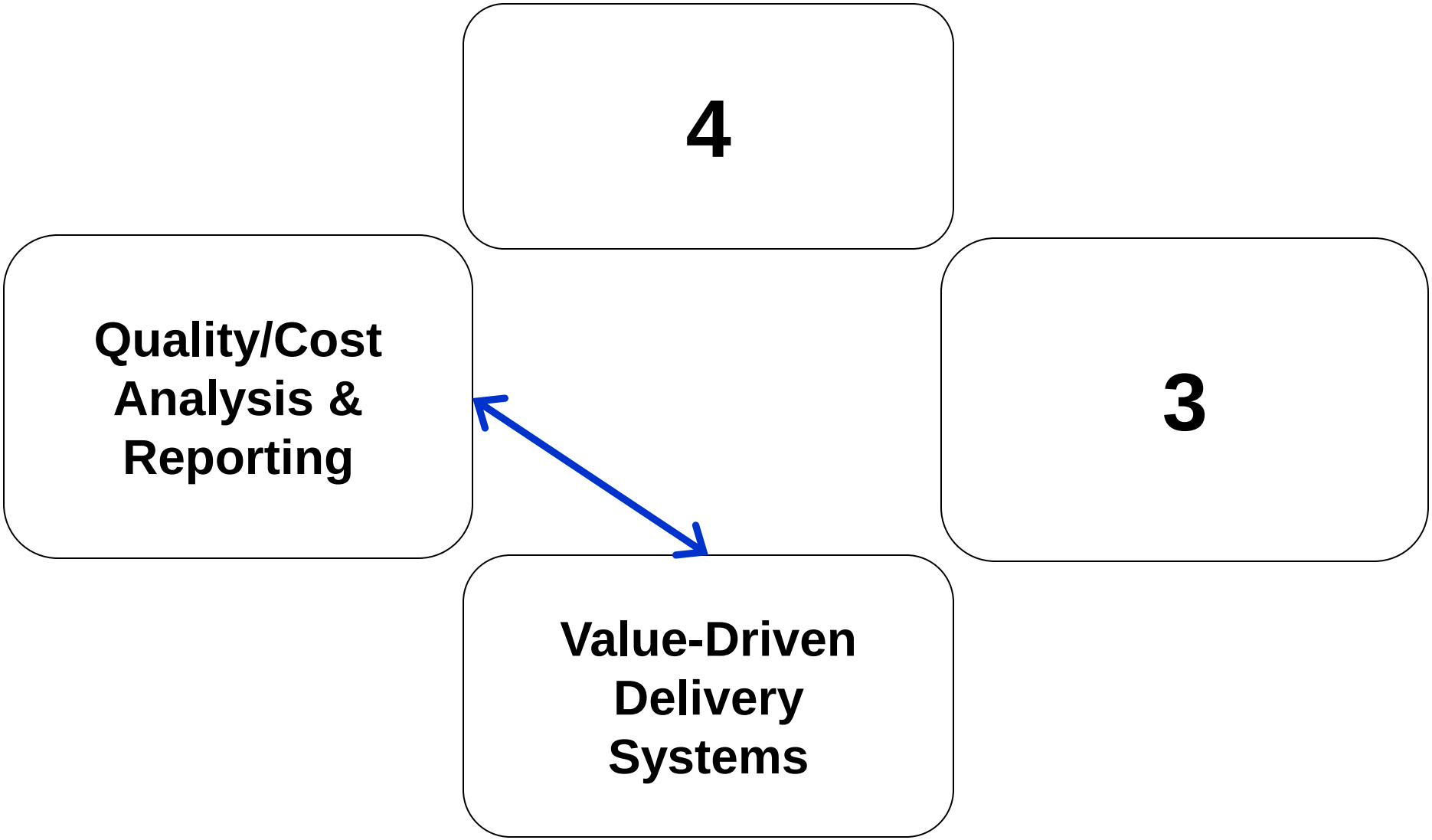
**4**

**Quality/Cost Analysis & Reporting**

**3**

**Value-Driven Delivery Systems**

# You Can't Manage What You Can't Measure



# Maine Physician Dashboards

## ABOUT YOUR PATIENTS

*Adult PCP Patients*

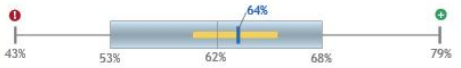
| | You | Peers |
|---|---|---|
| Patients | 345 | 275 |
| Average Age | 33 | 35 |
| % Male | 49 | 47 |
| % Chronic | 8.4 | 7.5 |
| % Asthma | 1.2 | 1.2 |
| % CAD | 1.6 | 1.3 |
| % COPD | 1.8 | 1.5 |
| % Diabetes | 1.8 | 2.0 |
| % Heart Failure | 2.0 | 1.5 |
| Risk Index | 1.05 | 1.0 |

*Click > Go to... to learn more about your performance scores*

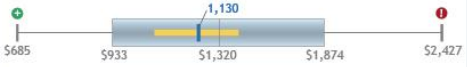
## PERFORMANCE SUMMARY

*Your overall performance compared to your peers.*

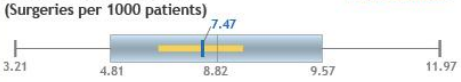
Effective Care (Quality) — *View details...*




Supply Sensitive Care (Efficiency) in Dollars — *View details...*



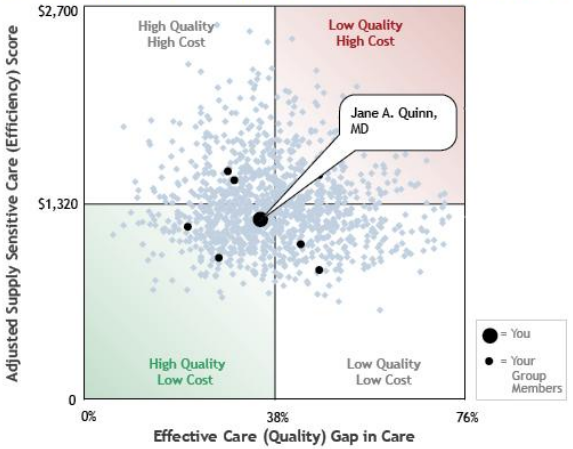

Preference Sensitive Care (Surgeries per 1000 patients) — *View details...*




= confidence interval
= Inter-quartile Range
= provider rate
= outlier

## QUALITY AND EFFICIENCY

*Your composite quality and efficiency scores compared to your peers.*




## KEY RISK ADJUSTED UTILIZATION MEASURES

> Go to ...

*Your use of services compared to your peers.*

| | You | Peers | Significantly Different from Peers |
|---|---|---|---|
| (PER 1000 PATIENTS) | | | |
| Admissions | 73 | 59 | ! |
| Hospital days | 293 | 289 | |
| Emergency Dept visits | 159 | 188 | |
| Prescriptions | 9 | 12 | |
| (OTHER) | | | |
| # of PCPs seen per patient | 1.4 | 1.9 | |
| # of Specialists seen per patient | 2.7 | 3.8 | |
| Physician Visits per patient | 8.9 | 11.8 | |
| % Generic Prescriptions | 73 | 68 | |

! = Your performance on this measure is significantly worse than your peers
+ = You performance on this measure is significantly better than your peers

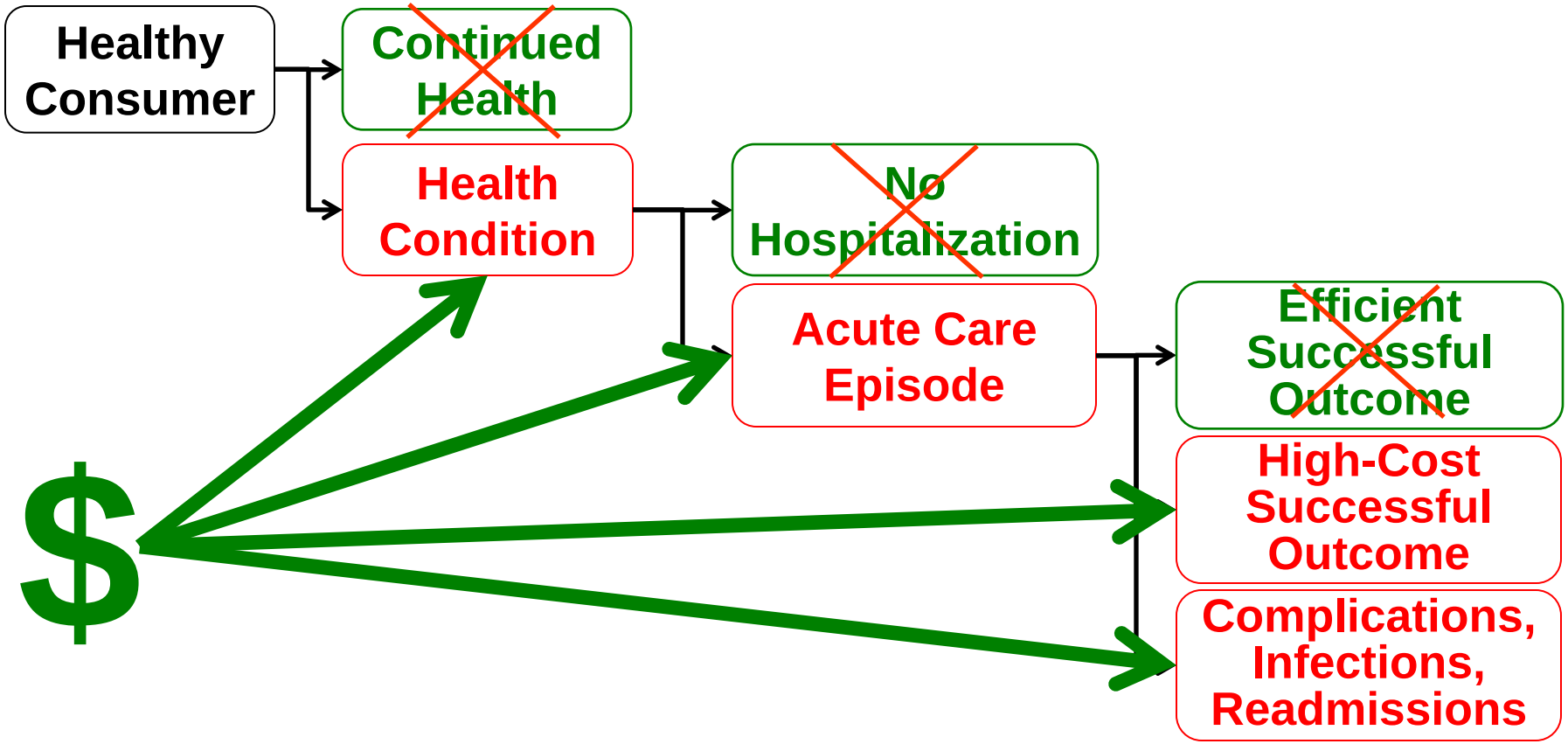
## PERFORMANCE IMPACT

> Go to...

*The impact of your performance compared to your peers.*

| Effective Care (Quality) | Patients | Rate | Peers | Diff | Opportunity for Change |
|---|---|---|---|---|---|
| Breast Cancer Screening (%) | 125 | 73 | 81 | 8 | 10 (Patients) |
| Diabetes - HbA1c Testing (%) | 27 | 80 | 87 | 7 | 2 (Patients) |
| CAD - Beta Blocker Post MI (%) | 14 | 92 | 98 | 6 | 1 (Patients) |
| **Supply Sensitive Care (Efficiency)** | | | | | |
| Advanced Imaging Cost (Dollars) | 345 | 45 | 28 | 17 | 5,693 |
| Outpatient Visit Cost (Dollars) | 345 | 346 | 305 | 41 | 14,007 |
| Specialist Visits (Visits) | 345 | 5.8 | 4.7 | 1.1 | 380 |
| **Preference Sensitive Care (Surgeries per 1000 patients)** | | | | | |
| Cardiac Revascularization | 45 | 22 | 19 | 2.4 | 1 (Patients) |
| Lumbar Back Surgery | 98 | 14 | 11 | 2.6 | 1 (Patients) |
| Knee Surgery | 75 | 9 | 6 | 2.4 | 1 (Patients) |

# Current Payment Systems Reward Bad Outcomes, Not Better Health



# Better Payment Systems is #3

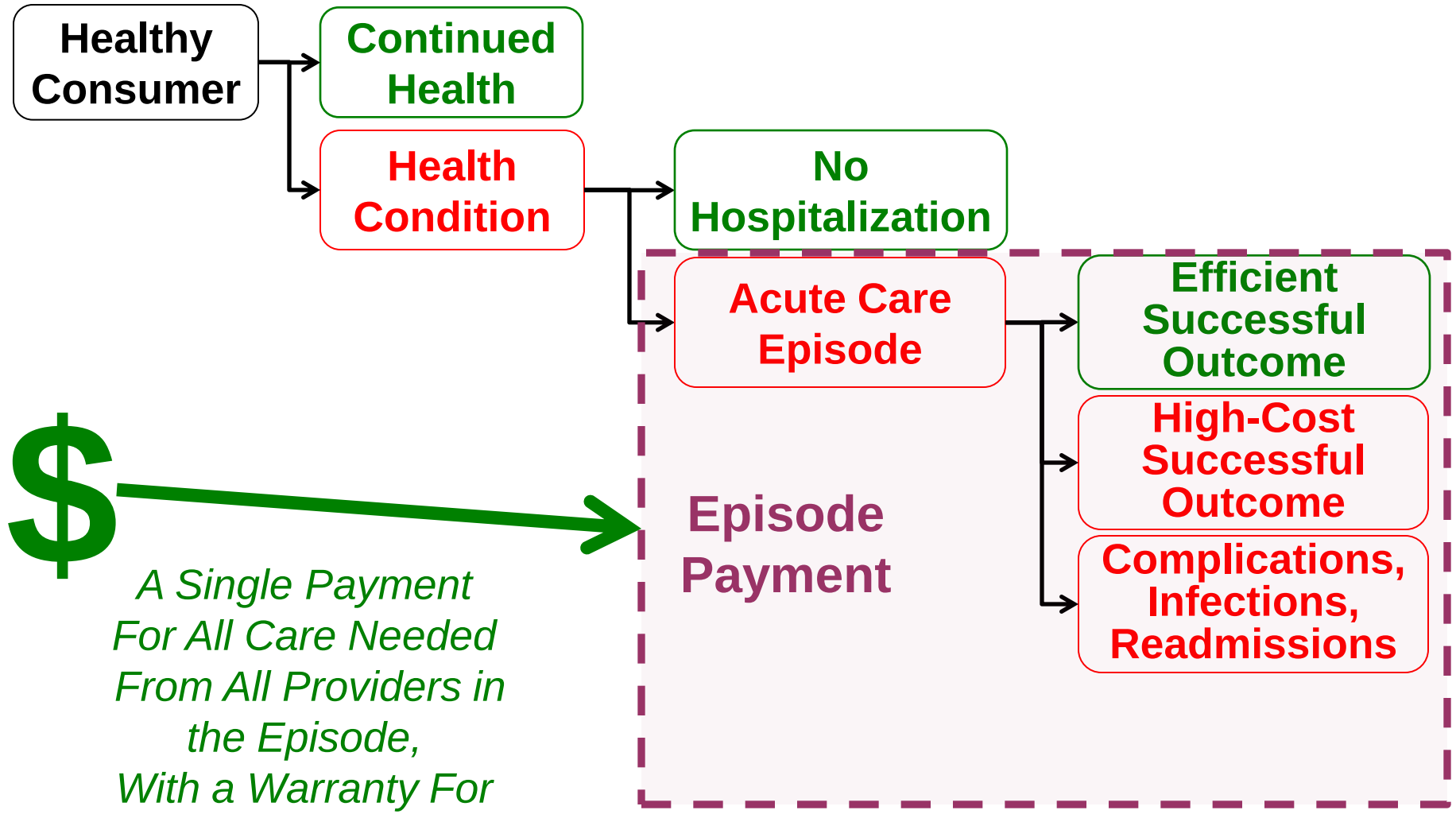
**4**

**Quality/Cost Analysis & Reporting**

**Value-Driven Payment Systems**

**Value-Driven Delivery Systems**

# "Episode Payments" to Reward Value *Within* Episodes



# Yes, a Health Care Provider Can Offer a *Warranty*

**Geisinger Health System ProvenCare℠**

- A single payment for an ENTIRE 90 day period including:
  - ALL related pre-admission care
  - ALL inpatient physician and hospital services
  - ALL related post-acute care
  - ALL care for any related complications or readmissions
- Types of conditions/treatments currently offered:
  - Cardiac Bypass Surgery
  - Cardiac Stents
  - Cataract Surgery
  - Total Hip Replacement
  - Bariatric Surgery
  - Perinatal Care
  - Low Back Pain
  - Treatment of Chronic Kidney Disease

# Payment + Process Improvement = Better Outcomes, Lower Costs

## ProvenCare® CABG Quality Clinical Outcomes - (18. mos)

| | *Before ProvenCare* (n=132) | *With ProvenCare* (n=181) | % Improvement/ (Reduction) |
|---|---|---|---|
| In hospital mortality | 1.5 % | 0 % | |
| Patients with any complication (STS) | 38 % | 30 % | **21 %** |
| Patients with >1 complication | 7.6 % | 5.5 % | **28 %** |
| Atrial fibrillation | 23 % | 19 % | **17 %** |
| Neurologic complication | 1.5 % | 0.6 % | **60 %** |
| Any pulmonary complication | 7 % | 4 % | **43 %** |
| Blood products used | 23 % | 18 % | **22 %** |
| Re-operation for bleeding | 3.8 % | 1.7 % | **55 %** |
| Deep sternal wound infection | 0.8 % | 0.6 % | **25 %** |
| Readmission within 30 days | 6.9 % | 3.8 % | **44 %** |

# It Can Be Done By Physicians, Not Just Health Systems

- In 1987, an orthopedic surgeon in Lansing, MI and the local hospital, Ingham Medical Center, offered:
  - a fixed total price for surgical services for shoulder and knee problems
  - a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, rehospitalization and additional surgery.
- Results:
  - Health insurer paid 40% less than otherwise
  - Surgeon received over 80% more in payment than otherwise
  - Hospital received 13% more than otherwise, despite fewer rehospitalizations
- Method:
  - Reducing unnecessary auxiliary services such as radiography and physical therapy
  - Reducing the length of stay in the hospital
  - Reducing complications and readmissions.

# Can Providers, Payers, & Patients All Benefit from Warranties?

# Example: $10,000 Procedure

| Cost of Procedure |
| --- |
| $10,000 |

# Actual Average Payment for Procedure is More than $10,000

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost |
|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 |

# Starting Point for Warranty Price: Current Actual Average Payment

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost | Price Charged | Change in Net Revenue |
|---|---|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 | $11,000 | $0 |

# Limited Warranty Gives Financial Incentive to Improve Quality

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost | Price Charged | Change in Net Revenue |
|---|---|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 | $11,000 | $0 |
| $10,000 | $20,000 | **4%** | $10,800 | $11,000 | **$200** |

Reducing Adverse Events…

...Reduces Costs...

…Improves The Bottom Line

# Higher-Quality Provider Can Charge Less, Attract More Patients

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost | Price Charged | Change in Net Revenue |
|---|---|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 | $11,000 | $0 |
| $10,000 | $20,000 | **4%** | $10,800 | $11,000 | **$200** |
| | | | | | |
| $10,000 | $20,000 | 4% | $10,800 | $10,800 | $0 |

Enables Lower Prices

# A Virtuous Cycle of Quality Improvement & Cost Reduction

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost | Price Charged | Change in Net Revenue |
|---|---|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 | $11,000 | $0 |
| $10,000 | $20,000 | 4% | $10,800 | $11,000 | $200 |
| | | | | | |
| $10,000 | $20,000 | 4% | $10,800 | $10,800 | $0 |
| $10,000 | $20,000 | **3%** | $10,600 | $10,800 | **$200** |

Reducing Adverse Events…

...Reduces Costs...

…Improves The Bottom Line

# Win-Win-Win for Patients, Payers, and Providers

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost | Price Charged | Change in Net Revenue |
|---|---|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 | $11,000 | $0 |
| $10,000 | $20,000 | 4% | $10,800 | $11,000 | $200 |
| | | | | | |
| $10,000 | $20,000 | 4% | $10,800 | $10,800 | $0 |
| $10,000 | $20,000 | 3% | $10,600 | $10,800 | $200 |
| | | | | | |
| $10,000 | $20,000 | 3% | $10,600 | $10,600 | $0 |
| $10,000 | $20,000 | 0% | $10,000 | $10,600 | $600 |

**Quality is Better...**

**...Cost is Lower...**

**...Providers More Profitable**

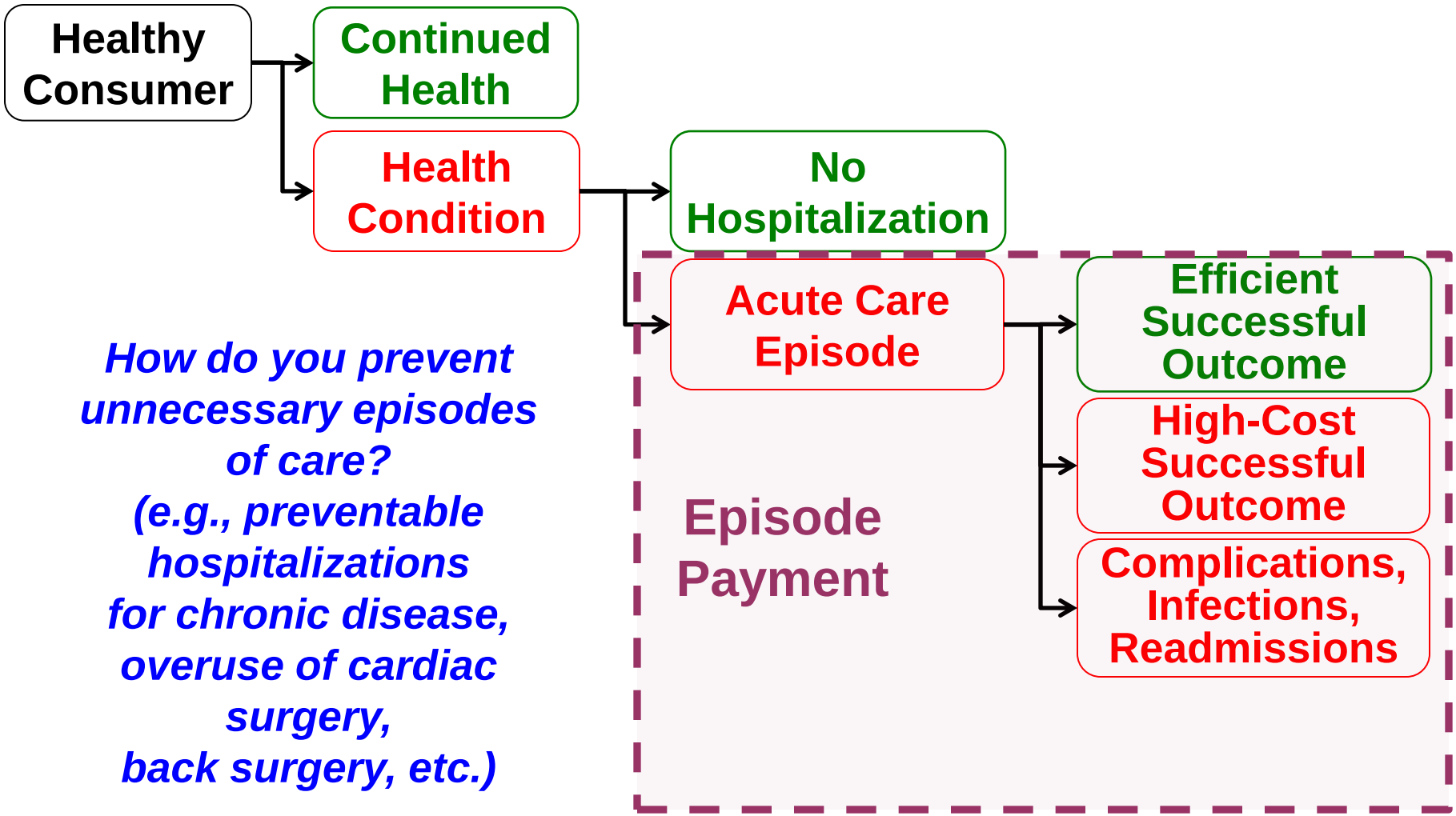
# In Contrast, Non-Payment Alone Creates Financial Losses

| Cost of Procedure | Added Cost of Infection | Rate of Infections | Average Total Cost | Amount Paid | Change in Net Revenue |
|---|---|---|---|---|---|
| $10,000 | $20,000 | 5% | $11,000 | $11,000 | $0 |
| $10,000 | $20,000 | 5% | $11,000 | $10,000 | -$1,000 |
| | | | | | |
| $10,000 | $20,000 | 3% | $10,600 | $10,000 | -$600 |
| | | | | | |
| $10,000 | $20,000 | 0% | $10,000 | $10,000 | $0 |

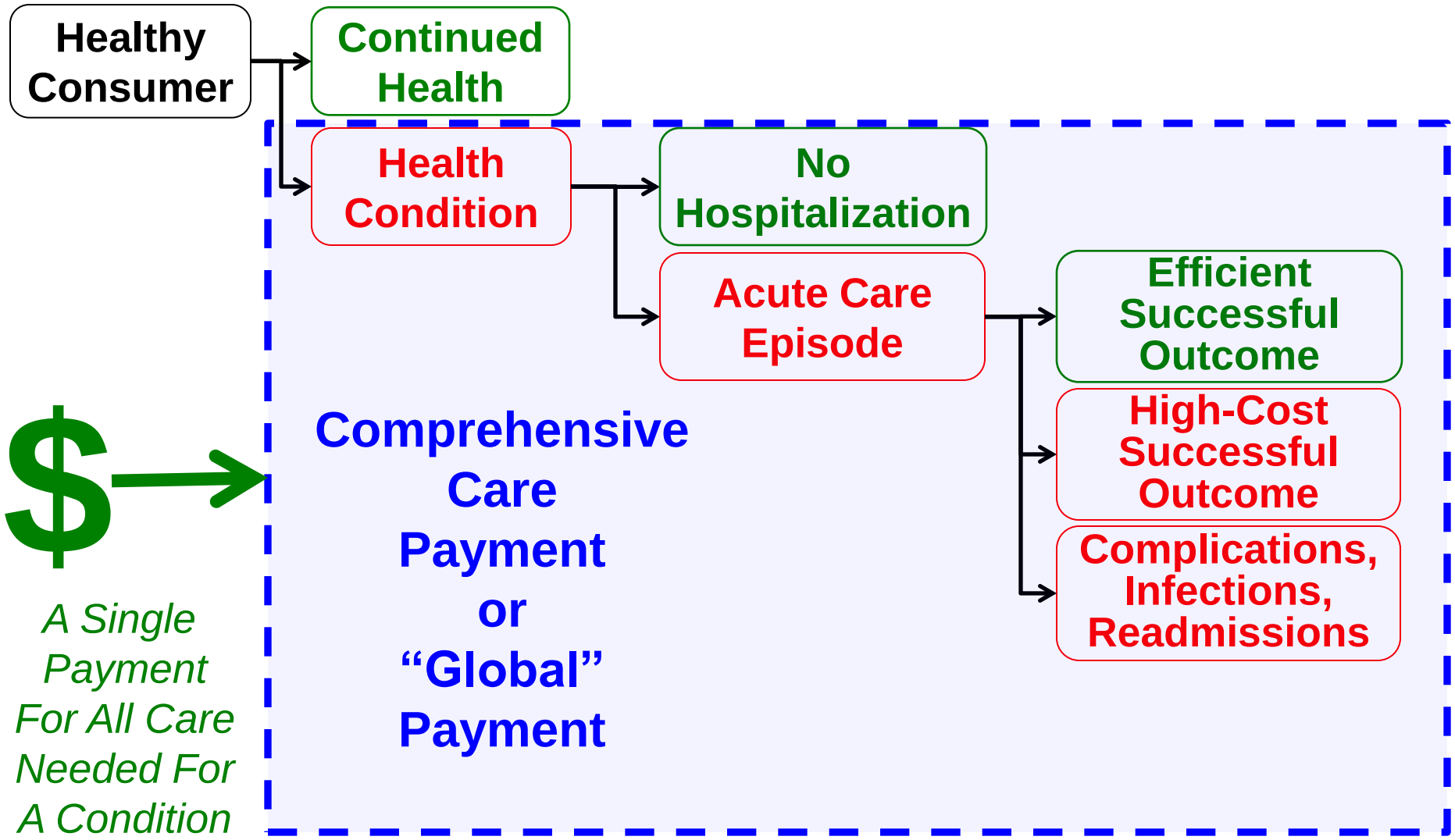
Non-Payment for Infections

Causes Losses While Improving

# The Weakness of Episode Payment



# Comprehensive Care Payments To *Avoid* Episodes



# Significant Reduction in Rate of Hospitalizations Possible

Examples:

- 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists

  J. Bourbeau, M. Julien, et al, "Reduction of Hospital Utilization in Patients with Chronic Obstructive Pulmonary Disease: A Disease-Specific Self-Management Intervention," *Archives of Internal Medicine* 163(5), 2003

- 66% reduction in hospitalizations for CHF patients using home-based telemonitoring

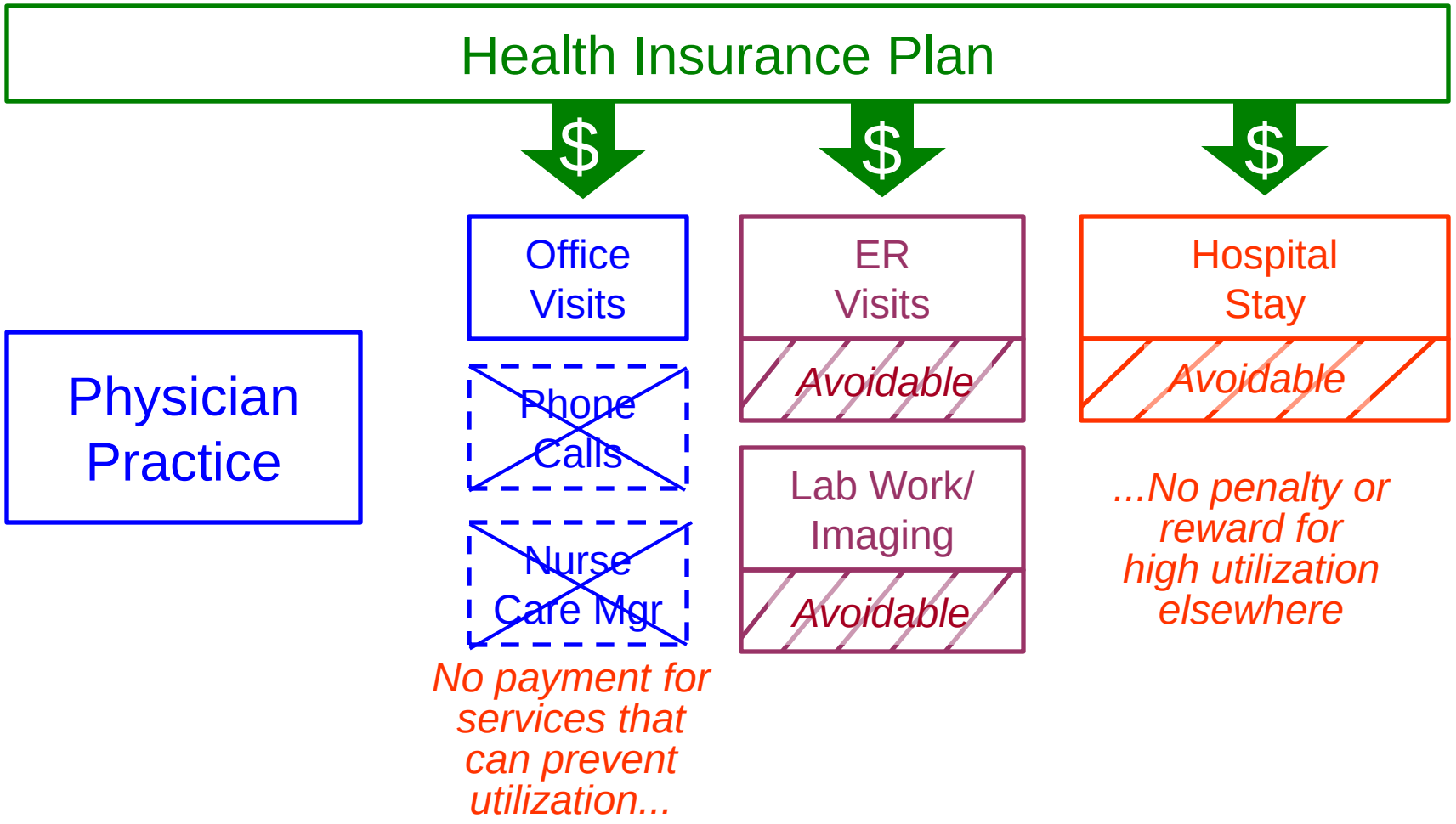
  M.E. Cordisco, A. Benjaminovitz, et al, "Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure," *American Journal of Cardiology* 84(7), 1999

- 27% reduction in hospital admissions, 21% reduction in ER visits through self-management education

  M.A. Gadoury, K. Schwartzman, et al, "Self-Management Reduces Both Short- and Long-Term Hospitalisation in COPD," *European Respiratory Journal* 26(5), 2005

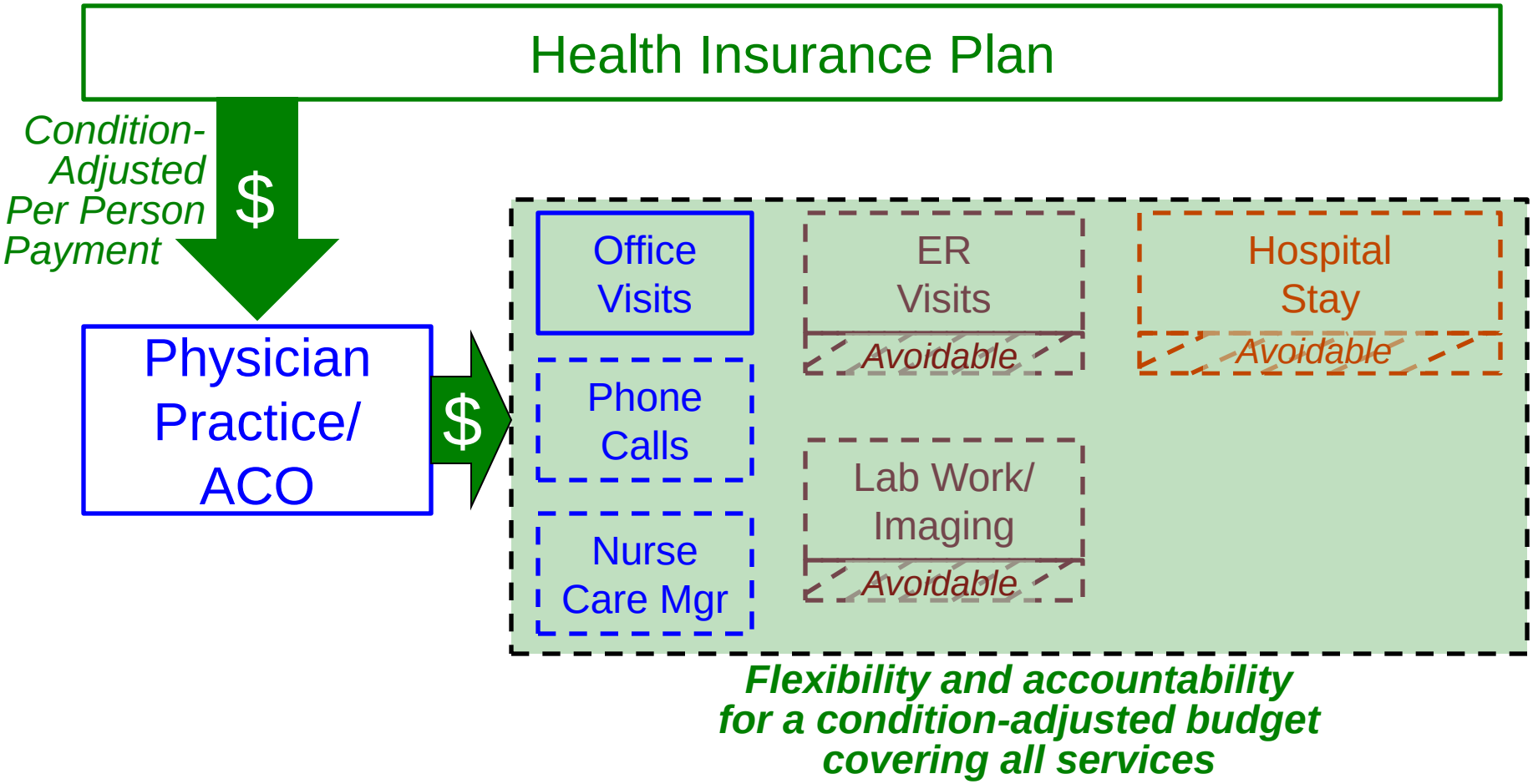
# We Don't Pay for the Things That Will Prevent Overutilization

## CURRENT PAYMENT SYSTEMS

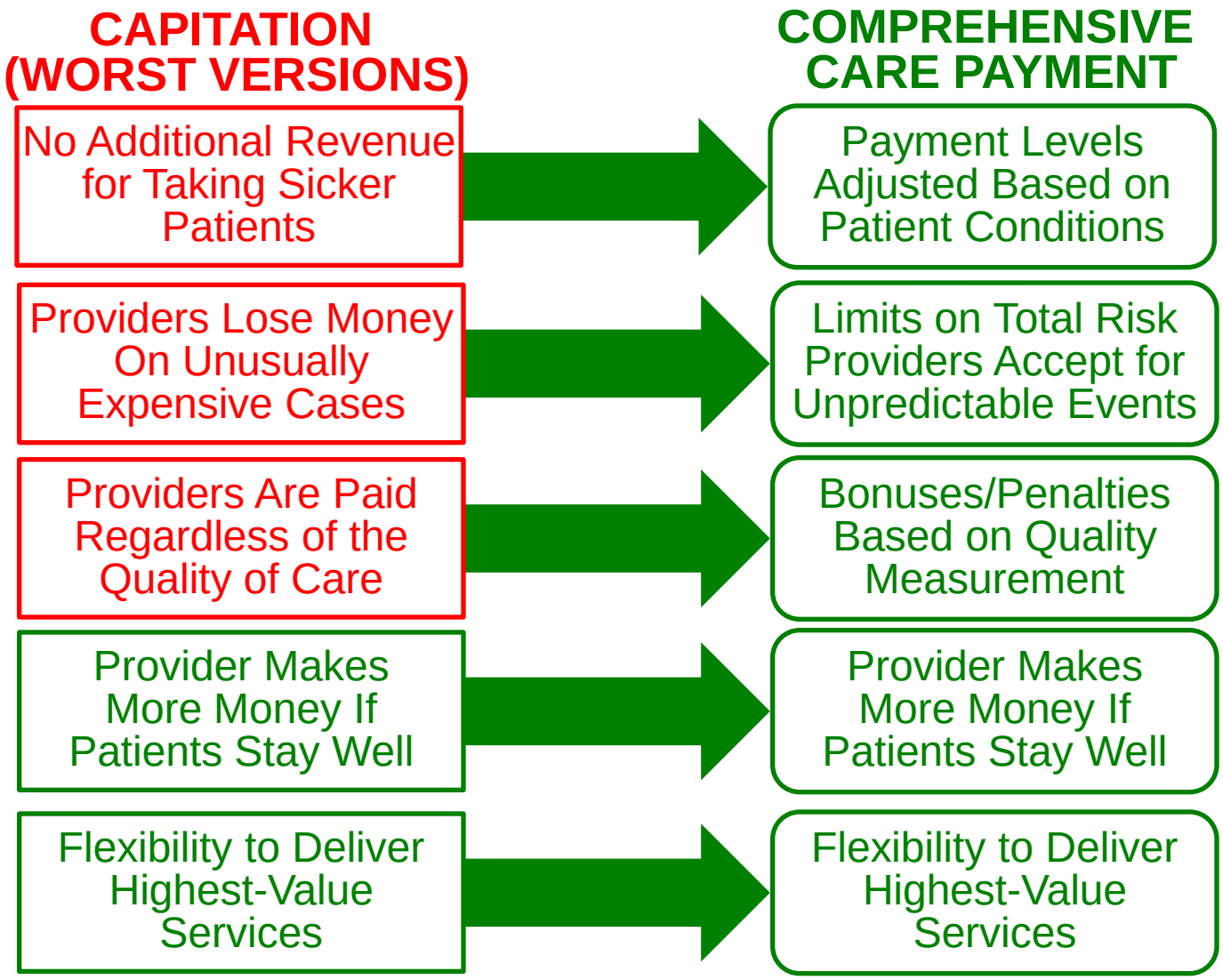


# Comprehensive Care Payment Provides Flexibility+Accountability

## COMPREHENSIVE CARE/GLOBAL PAYMENT



# Isn't This Capitation (Ugh)? No – It's Different



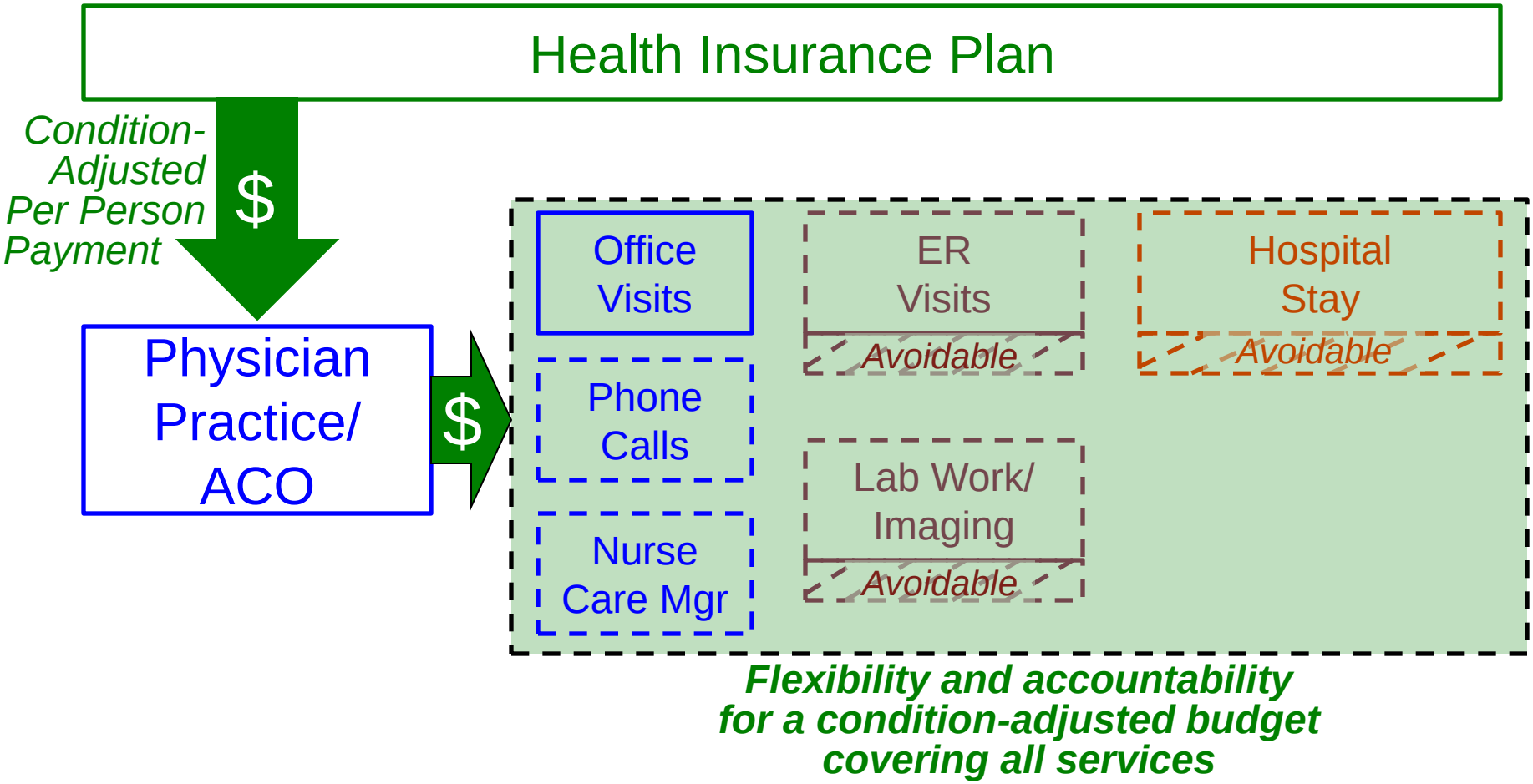
# Example: BCBS Massachusetts Alternative Quality Contract

- Single payment for all costs of care for a population of patients
  - Adjusted up/down annually based on severity of patient conditions
  - Initial payment set based on past expenditures, not arbitrary estimates
  - Provides flexibility to pay for new/different services
  - Bonus paid for high quality care
- Five-year contract
  - Savings for payer achieved by controlling increases in costs
  - Provider can reap returns on investment in prevention, infrastructure
- Analytic support to identify opportunities & monitor progress
- Broad participation
  - 14 physician groups/health systems participating with over 400,000 patients, including one primary care IPA with 72 physicians
- Positive first-year results
  - Higher ambulatory care quality than non-AQC practices, better patient outcomes, lower readmission rates and ER utilization

http://www.bluecrossma.com/visitor/about-us/making-quality-health-care-affordable.html

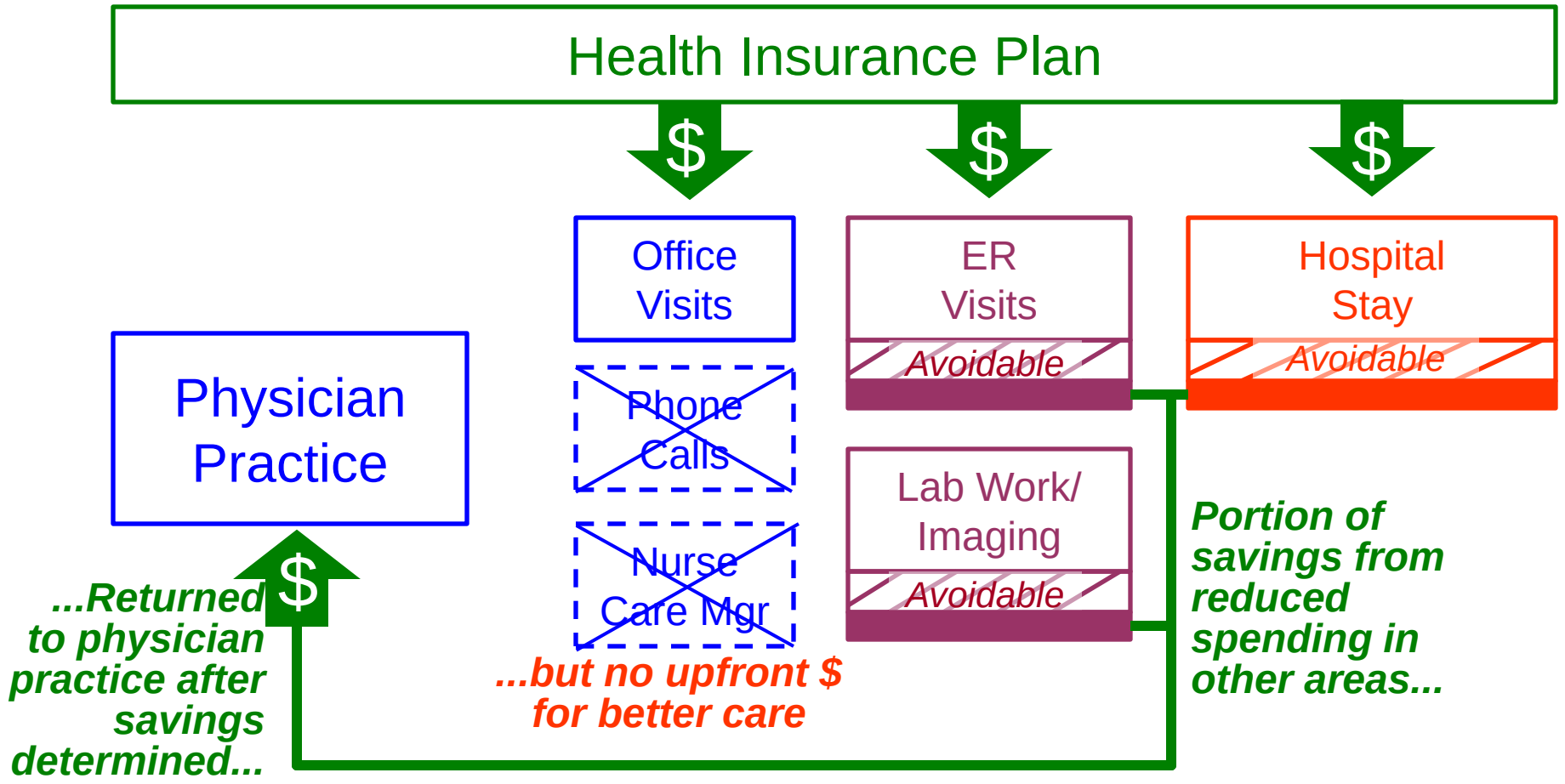
# Comprehensive Care Payment Is a Big Jump from FFS

## COMPREHENSIVE CARE/GLOBAL PAYMENT



# Is Shared Savings a Good Transitional Model?

## SHARED SAVINGS MODEL

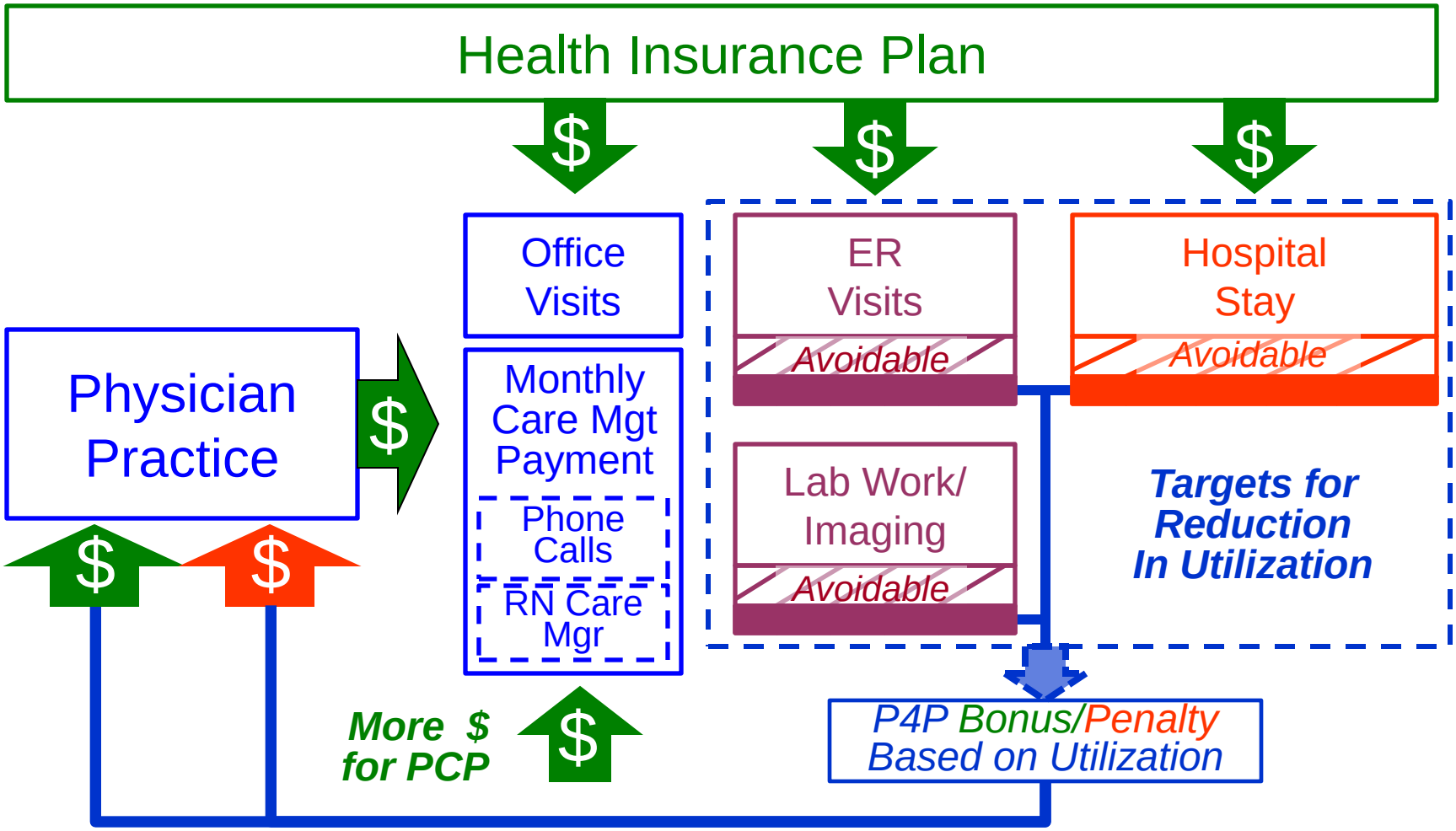


# Weaknesses of “Shared Savings”

- Provides no upfront money to enable physician practices to hire nurse care managers, install IT, etc.; additional funds, if any, come years after the care changes are made
- Requires TOTAL costs to go down in order for the physician practice to receive ANY increase in payment, even if the practice can’t control all costs
- Gives more rewards to the *poor* performers who improve than the providers who’ve done well all along
- The underlying fee for service incentives continue; losing less (via shared savings) is still losing compared to FFS
- I.e., it’s not really true *payment reform*

# A Better Transition: Simulate Flexibility/Incentives of Global Pmt

## CARE MGT PAYMENT + UTILIZATION P4P



# Example: A Hypothetical Underpaid PCP Practice

| PRIMARY CARE PRACTICE | |
|---|---|
| PCPs | 4 |
| Patients/Physician | 2,000 |
| PMPY Primary Care Cost | $140 |
| Annual Revenue | $1,120,000 |
| Overhead Costs | $400,000 |
| Physician Salary | $180,000 |

# Many Patients Are Going to ER Due to Difficulty Seeing PCPs

| PRIMARY CARE PRACTICE | |
|---|---|
| PCPs | 4 |
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| Overhead Costs | $400,000 |
| Physician Salary | $180,000 |

| HEALTH PLAN ER EXPENSES | |
|---|---|
| ER Visits/1000 | 200 |
| % Preventable | 40% |
| Per ER Visit | $1,000 |
| ER Visit Cost to Payer | $640,000 |

# PCPs Could Reduce ER Expenses With Right Resources

| PRIMARY CARE PRACTICE | | | HEALTH PLAN ER EXPENSES | |
|---|---|---|---|---|
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| | | | | |
| Cost of Nurse Practitioner | $80,000 | | Reduction in Prev. ER Visits | 40% |
| Other Costs | $10,000 | | Savings | $256,000 |
| Total Costs | $90,000 | | | |

# Upfront Money Could *Enable* PCPs to Change, If Willing

| PRIMARY CARE PRACTICE | | | HEALTH PLAN ER EXPENSES | |
|---|---|---|---|---|
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| | | | | |
| Upfront Payment | $90,000 | | Payment to Practice | $90,000 |
| | | | Net Savings to Payer | $166,000 |

# Payer Can Reward PCP for Results and Still Save Money

| PRIMARY CARE PRACTICE | | | HEALTH PLAN ER EXPENSES | |
|---|---|---|---|---|
| PCPs | 4 | | ER Visits/1000 | 200 |
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| | | | Net Savings to Payer | $166,000 |
| | | | | |
| Share of Savings | $83,000 | | Share to Practice | 50% |
| New Physician Salary | $200,750 | | Net Savings to Payer | $83,000 |
| Increase in Phys. Salary | 12% | | % Savings to Payer | 13% |

# Win-Win-Win for PCPs, Patients, & Premiums

| PRIMARY CARE PRACTICE | | HEALTH PLAN ER EXPENSES | |
|---|---|---|---|
| PCPs | 4 | ER Visits/1000 | 200 |
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# *Upfront* Payment Reform Needed So Care Can Be Changed

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# And Outcome Targets Need to Be Things Physicians Can Influence

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# Example: Washington State Medical Home Pilot Program

- Payers will pay the Primary Care Practice an upfront PMPM Care Management Payment for all patients ($2.50 first year, $2.00 future years)
- Practice agrees to reduce rate of non-urgent ER visits and ambulatory care-sensitive hospital admissions by amounts which will generate savings for payers at least equal to the Care Management Payment (targets are practice specific)
- If a practice reduces ER visits and hospitalizations by more than the target amount, the payer shares 50% of the net savings (gross savings minus the PMPM) with the practice
- If a practice fails to meet its ER/hospitalization targets, the practice pays a penalty via a reduction in its FFS conversion factor equivalent to up to 50% of Care Management Payment

# Wait for a Federal Solution? Look Who's Actually Leading...

| | STATES & REGIONAL COLLABORATIVES | CONGRESS/ MEDICARE |
|---|---|---|
| Pay for Performance | Most regions and payers have some form of P4P for hospitals and/or MDs | Just implementing hospital P4P in 2011 |
| Medical Homes | Major initiatives underway in CO, LA, MA, ME, MI, MN, NC, OR, PA, RI, VT, WA, etc. | Advanced Primary Care Demo based on 8 state medical home programs |
| Episode/Bundled Payment | Bundling/warranty initiatives underway or starting in California, Pennsylvania, Wisconsin, others | ACE bundling demo implemented in 2009 in four states; just announced new prog. |
| Total Cost Accountability | Physician groups/IPAs in CA, CO, MA, TX, WA, etc. paid by capitation/global pmt | Shared savings demos with 10 large MD groups |

# Better Payment Systems Require Good Quality Measurement

- Concern:  Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

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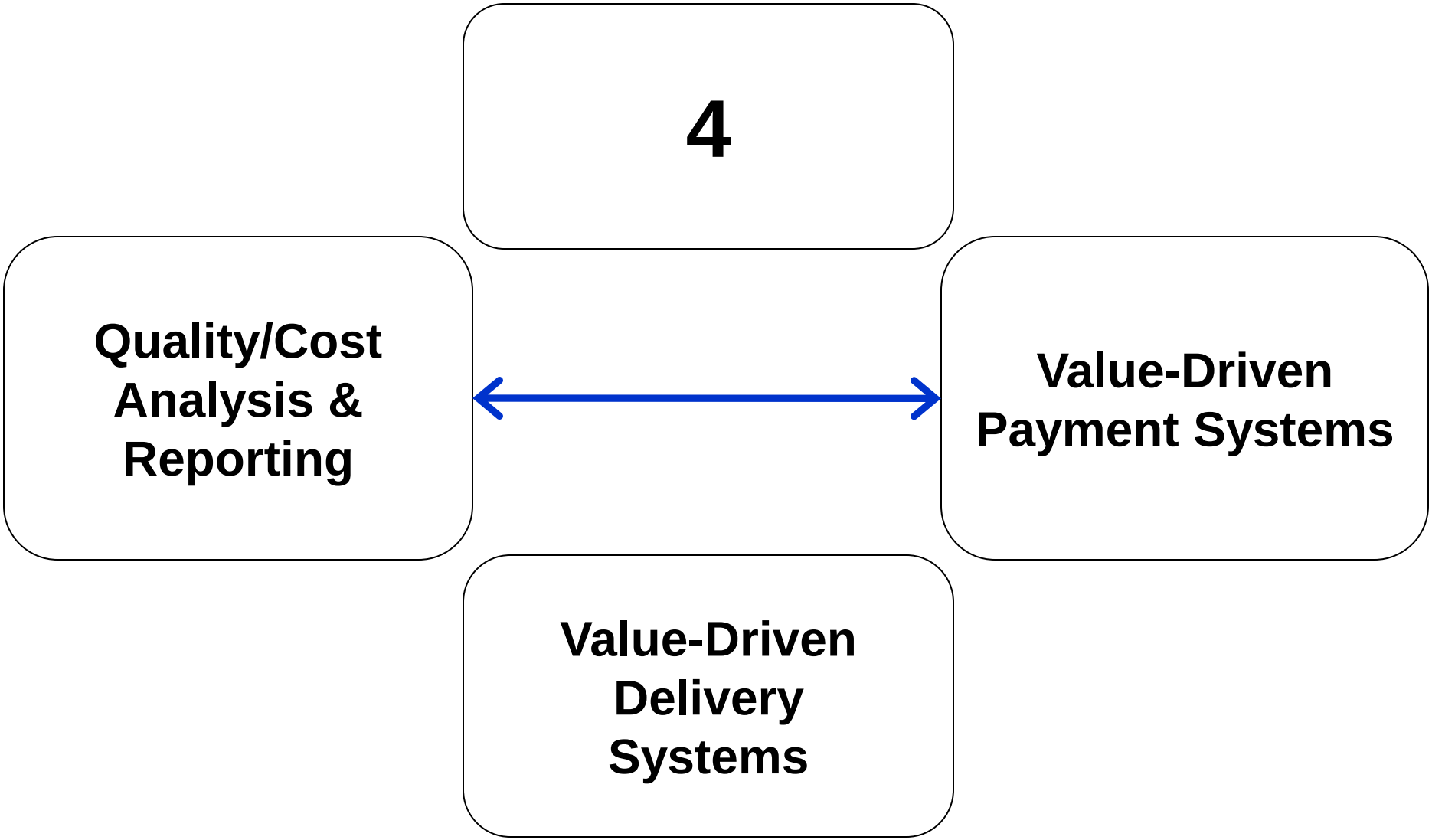
- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

# Community-Driven Quality Measurement

- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- Solution: Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs
- Ideal: Develop quality measures *with participation of physicians and hospitals*, as a growing number of regions do

# Measurement Supports Payment, As Well As Vice Versa



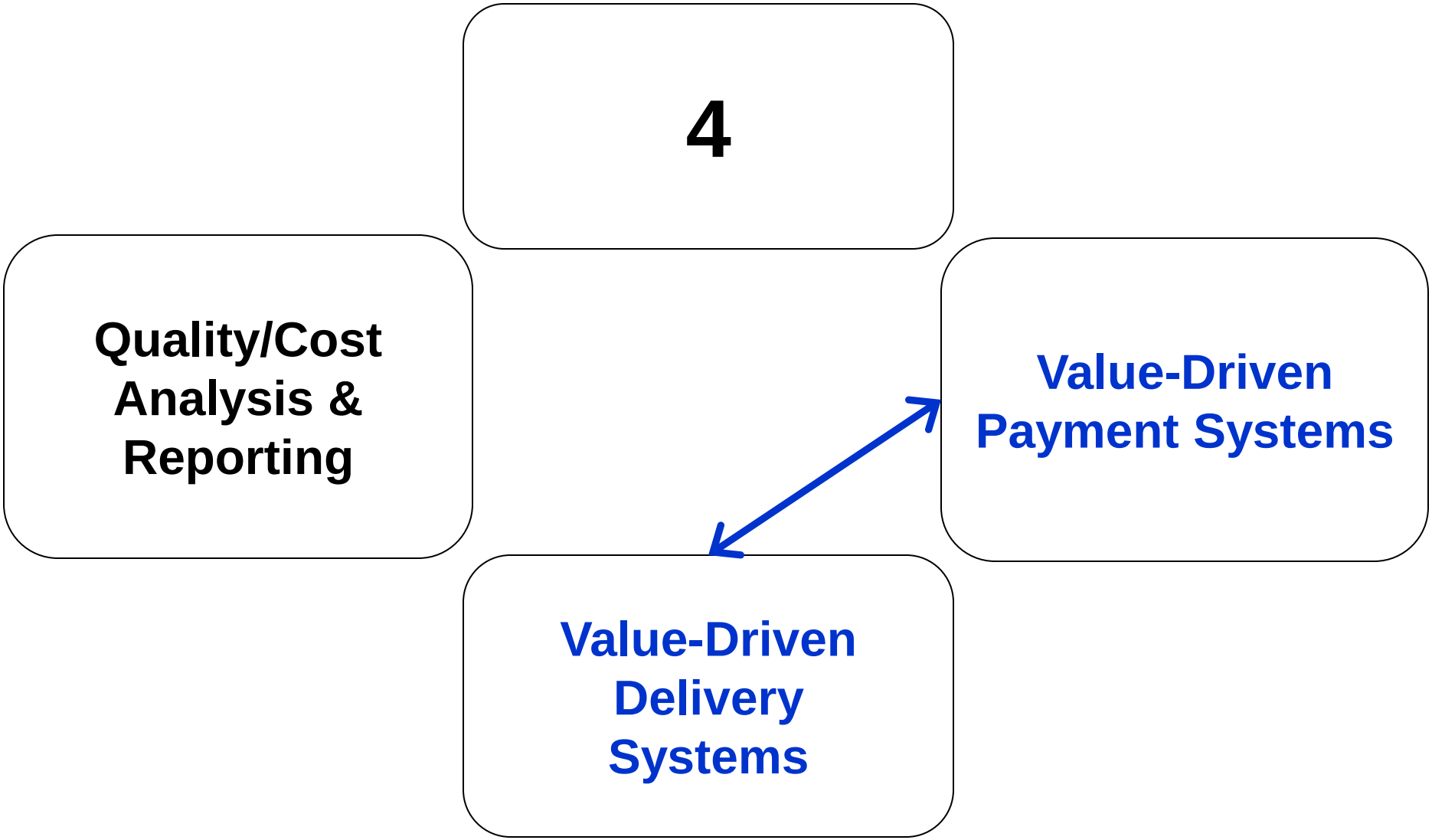
# It's Not Just The Right Payment *Method*, But Also the Right *Price*

- Improving the structure and incentives of payment systems is necessary but not sufficient
- The payment *level* is as important as the *method*
  - If payment level is (too) high, there will be no savings and little incentive to transform care
  - If payment level is too low, providers will be unable to deliver high-quality care and risk financial disaster
- Medicare dictates prices, but private payers negotiate them

# Need for Shared, Trusted Data For Pricing Episode/Global Pmt

- **Provider** needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount will cover its costs of delivering care
- **Purchaser** needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount is a better deal than they have today
- **Both** sets of data have to match in order for both purchasers and providers to agree!

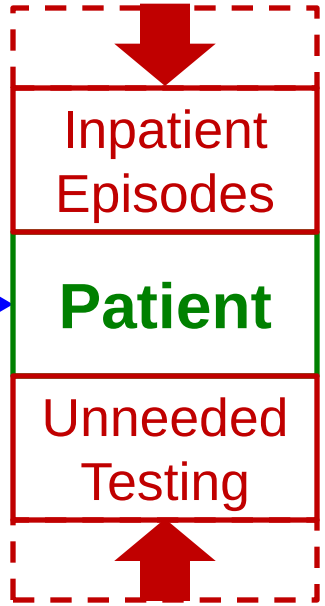
# Payment Systems & Delivery Systems Must Co-Evolve



# How Doctors Will Need to Change to Deliver "Accountable Care"

**Physician Practice + Partners = ACO**

- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with other specialists and hospitals
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- MD w/ time for diagnosis, treatment planning, and followup

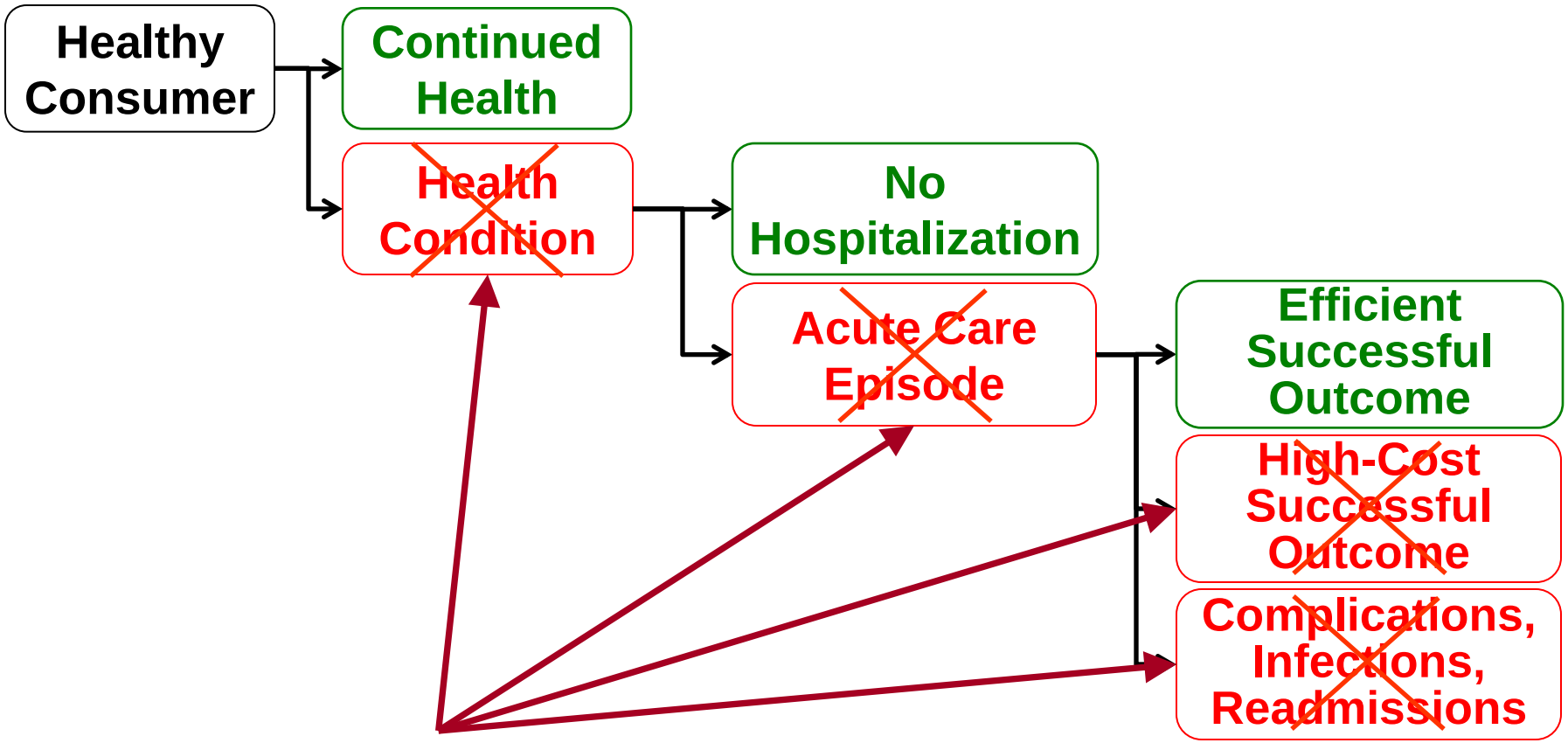


# Examples of Small Physician Practices Using Global Payment

- Small Primary Care Practices Managing Global Payments
  - Physician Health Partners (PHP) in Denver, CO is a management services organization that supports four separate IPAs (median size: 3 MDs/practice). PHP accepts capitated risk-based contracts on behalf of the IPAs with both Medicare and commercial HMOs. www.phpmcs.com
- Independent PCPs & Specialists Managing Global Payments
  - Northwest Physicians Network (NPN) in Tacoma, WA is an IPA with 109 PCPs and 345 specialists in 165 practices (average size: 2.4 MDs/practice). NPN accepts full or partial risk capitation contracts, operates its own Medicare Advantage plan, and does third party administration for self-insured businesses. www.npnwa.net
- Joint Contracting by MDs & Hospitals for Global Payments
  - The Mount Auburn Cambridge IPA (MACIPA) and Mount Auburn Hospital jointly contract with three major Boston-area health plans for full-risk capitation. The IPA is independent of the hospital; they coordinate care with each other without any formal legal structure. www.macipa.com

# How Will Hospitals Have to Change?

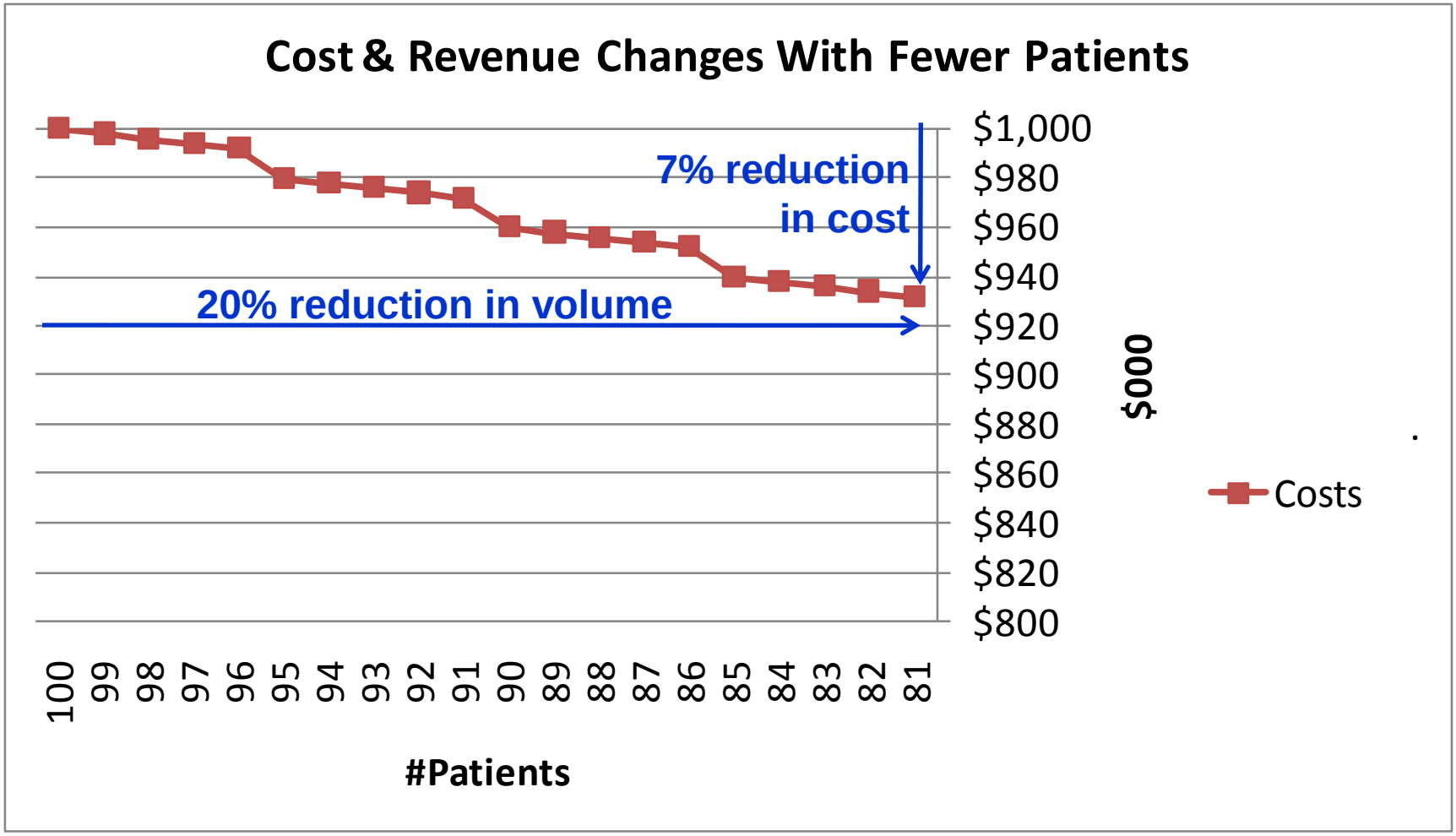
# Reducing Costs Without Rationing Reduces Hospital Revenues



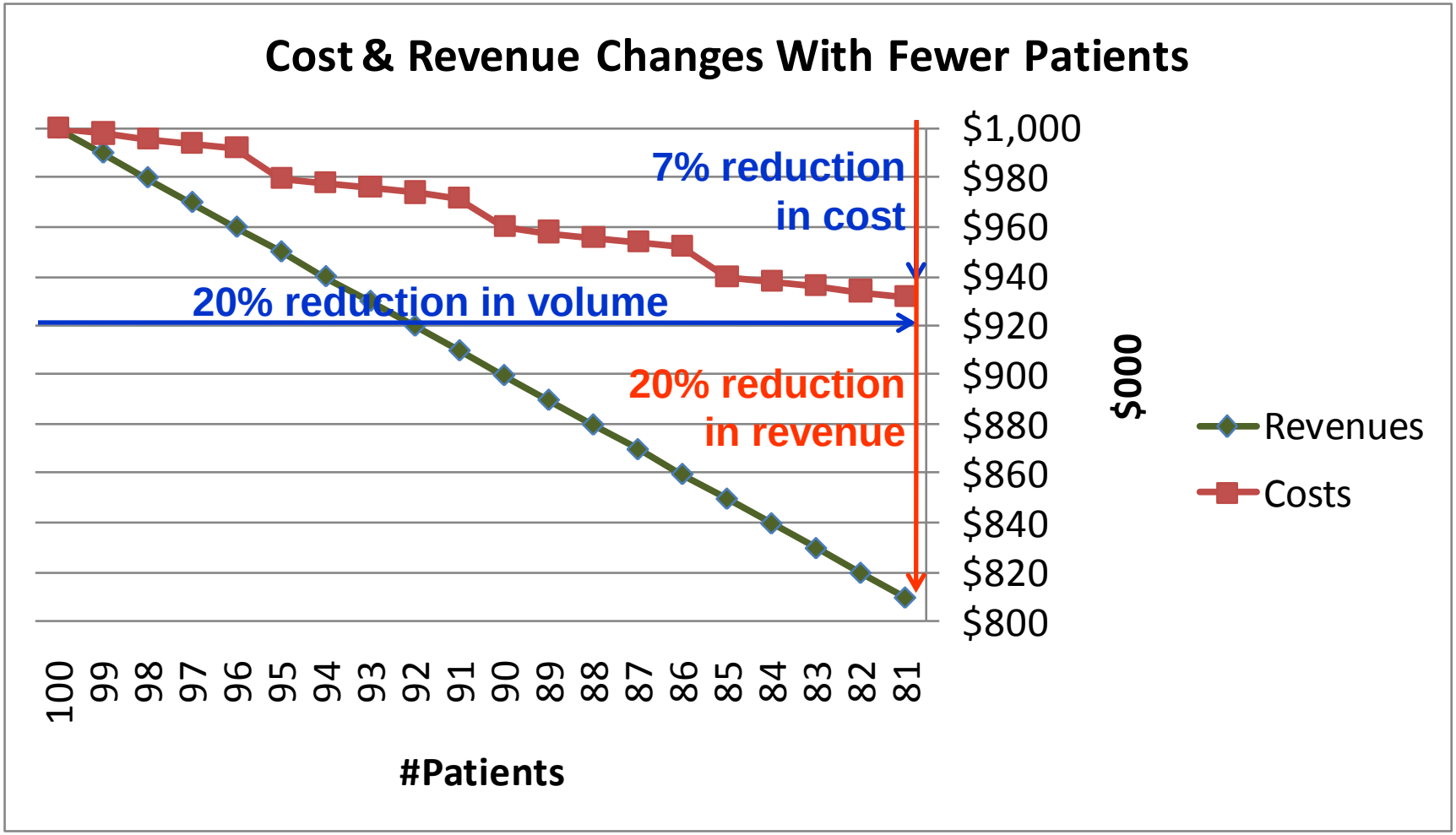
# How Will Hospitals Have to Change?

- Answer:  Smaller and higher-priced
- Huh????  Higher priced??
- In most industries, we want volume to go up, and when it does, prices go down.
  Why?  Fixed costs are spread more broadly.
- In the health care industry, we don't want it to sell more products/services in total.
- In hospitals, most costs are fixed costs
- Implication: lower volume means *higher unit cost* (just like every other industry), although *total spending* should still be lower

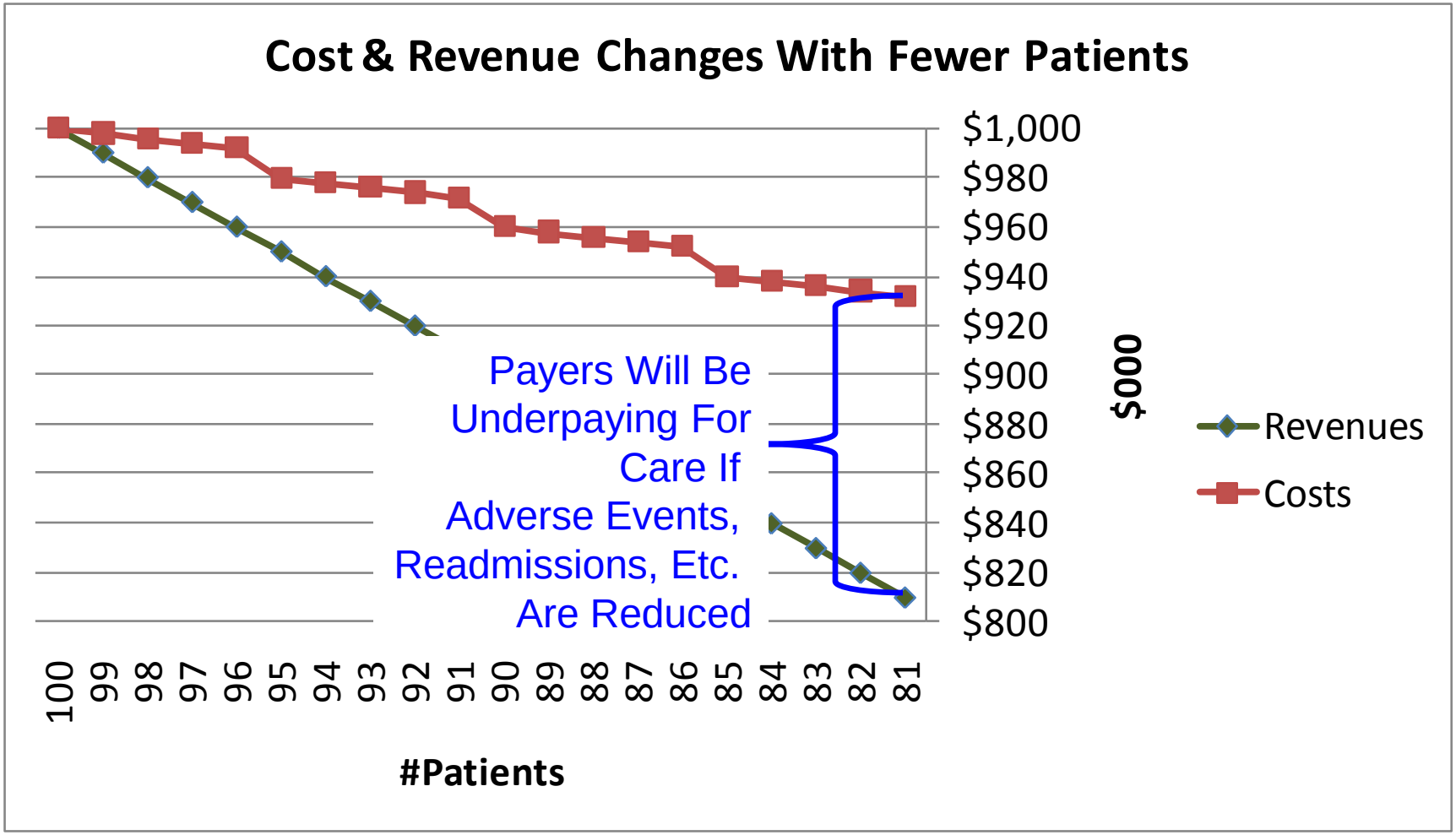
# Hospital Costs Are Not Proportional to Utilization



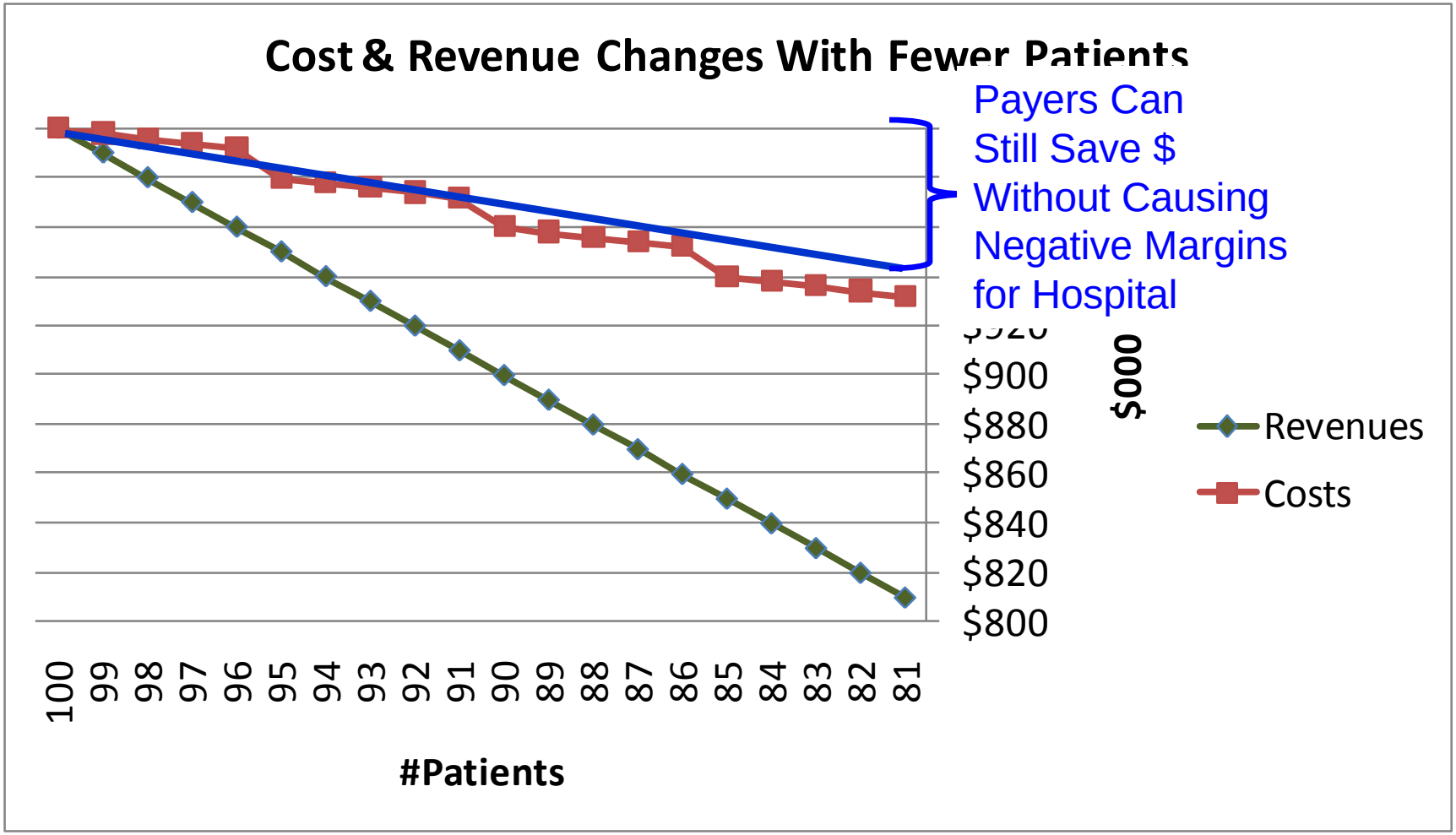
# Reductions in Utilization Reduce Revenues More Than Costs



# Causing Negative Margins for Hospitals



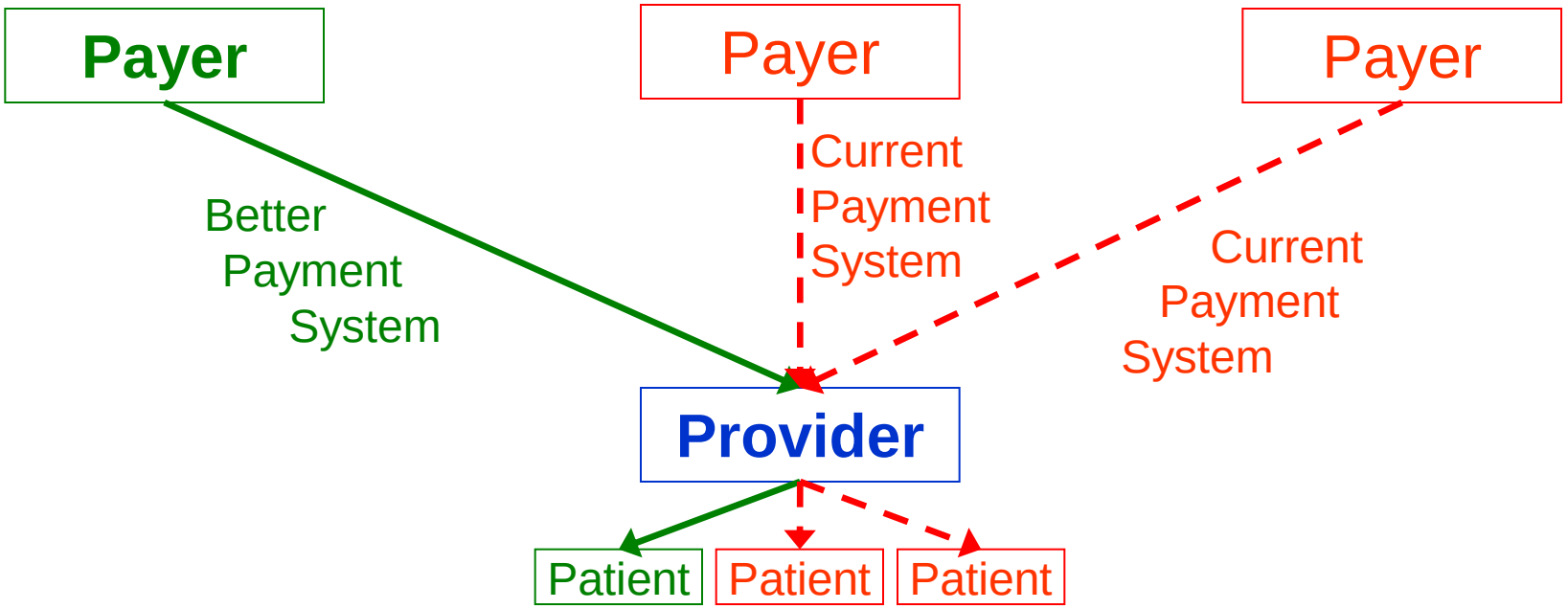
# So Prices Need to Be Re-Set Under Payment Reform



# Creating A Feasible Glide Path to the Future for Hospitals

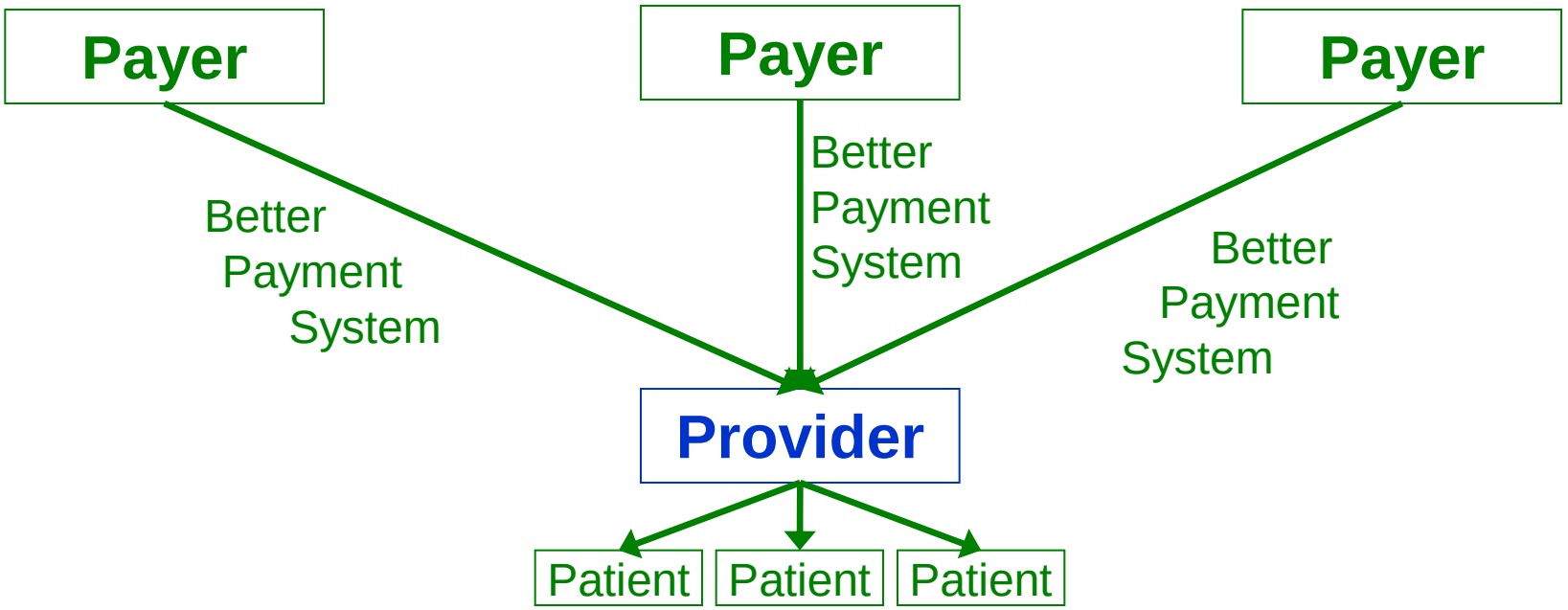
- For a hospital that's constantly full and growing, a reduction in chronic disease admissions may be welcome, particularly since they may be less profitable than elective surgery cases
- But for small community hospitals with empty beds, and hospitals with narrow operating margins, reductions in chronic disease admissions and readmissions could cause serious financial problems, particularly in the short run
- In the long run, with sufficient reductions in admissions, a hospital could restructure to reduce its fixed costs (close units, etc.), but it will take time
- Consequently, payers and hospitals will need to renegotiate payment levels to enable hospitals to remain solvent
- Both hospitals and payers will need a better understanding of hospital *costs* to determine what payment level is needed

# One Payer Changing Is Not Enough

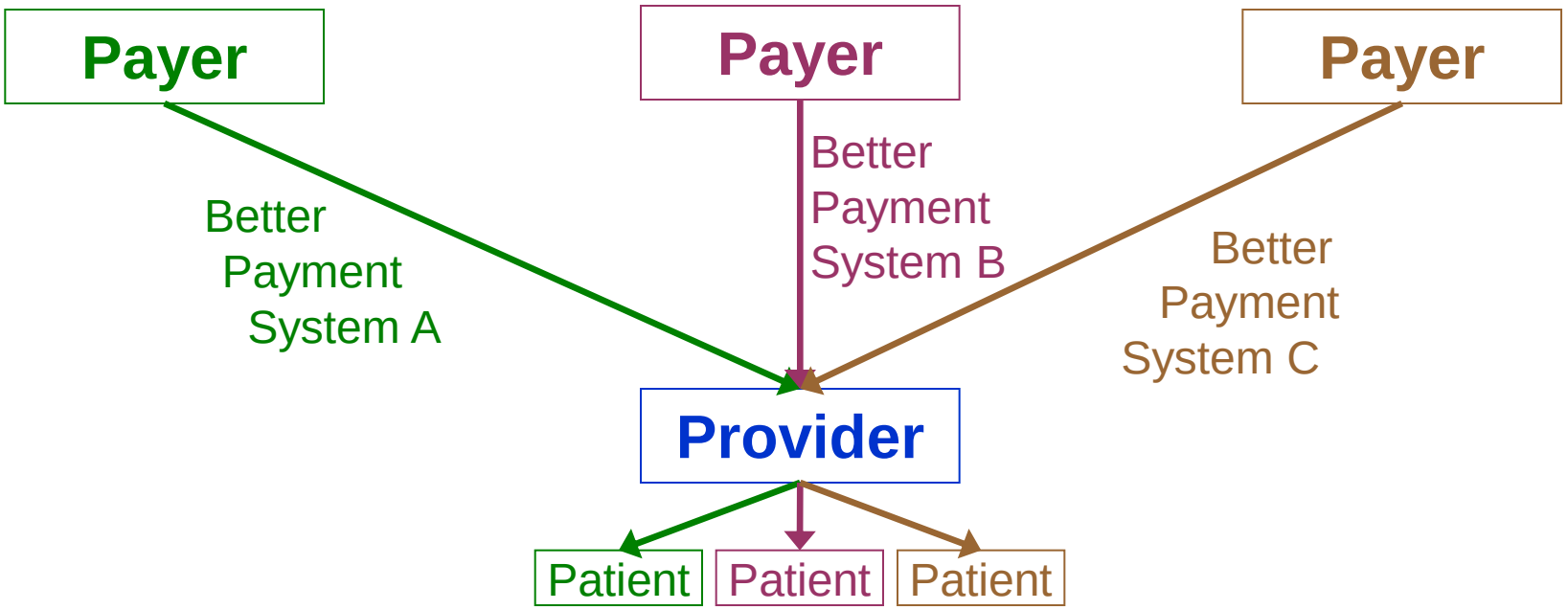



***Provider is only compensated for changed practices for the subset of patients covered by participating payers***

# All Payers Need to Change to Enable Providers to Transform



# Payers Need to Truly *Align* to Allow Focus on Better Care




Even if every payer's system is *better* than it was, if they're all *different*, providers will spend too much time and money on administration rather than care improvement

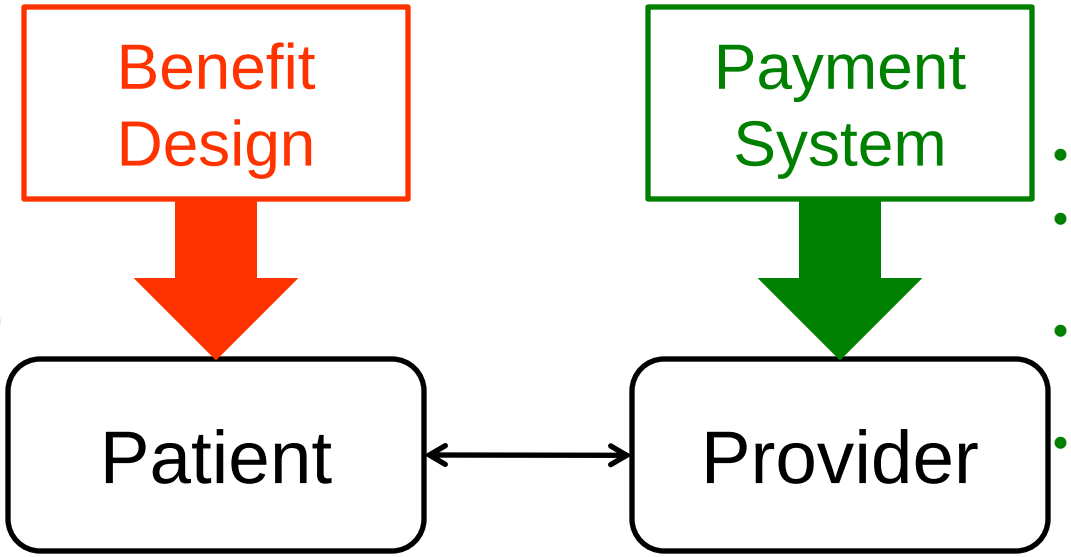
# Payer Coordination Is Beginning to Occur Around the Country

- Examples of Multi-Payer Payment Reforms:
  - Colorado, Maine, Michigan, Minnesota, New York, North Carolina, Oregon, Pennsylvania, Rhode Island ,Vermont, and Washington all have multi-payer medical home initiatives
- A Facilitator of Coordination is Needed
  - State Government (provides anti-trust exemption)
  - Non-profit Regional Health Improvement Collaboratives
- Medicare Needs to Participate in Local Projects as Well as Define its Own Demonstrations
  - Center for Medicare and Medicaid Innovation (CMMI) created under PPACA provides the opportunity for this
  - Medicare is now participating in eight of the state-led multi-payer medical home initiatives

# Benefit Design Changes Are Also Critical to Success

**Ability and Incentives to:**

- Improve health
- Take prescribed medications
- Allow a provider to coordinate care
- Choose the highest-value providers and services



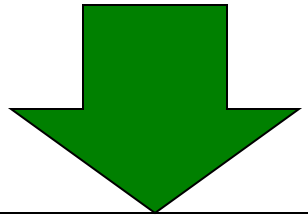

**Ability and Incentives to:**

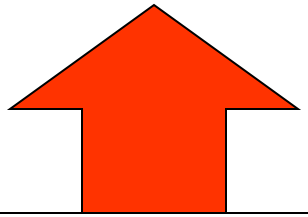
- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

# Example: Coordinating Pharmacy & Medical Benefits

Single-minded focus on reducing costs here...

...could result in higher spending on hospitalizations





**Pharmacy Benefits**

Drug Costs

- High copays for brand-names when no generic exists
- Doughnut holes & deductibles

**Medical Benefits**

Hospital Costs

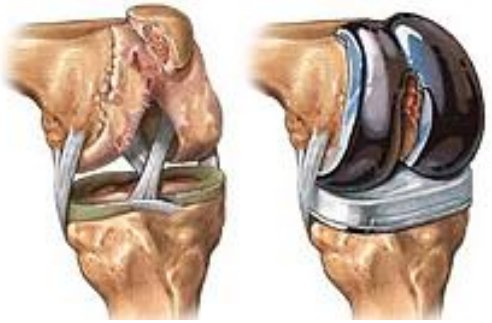
Physician Costs

Other Services

*Principal treatment for most chronic diseases involves regular use of maintenance medication*

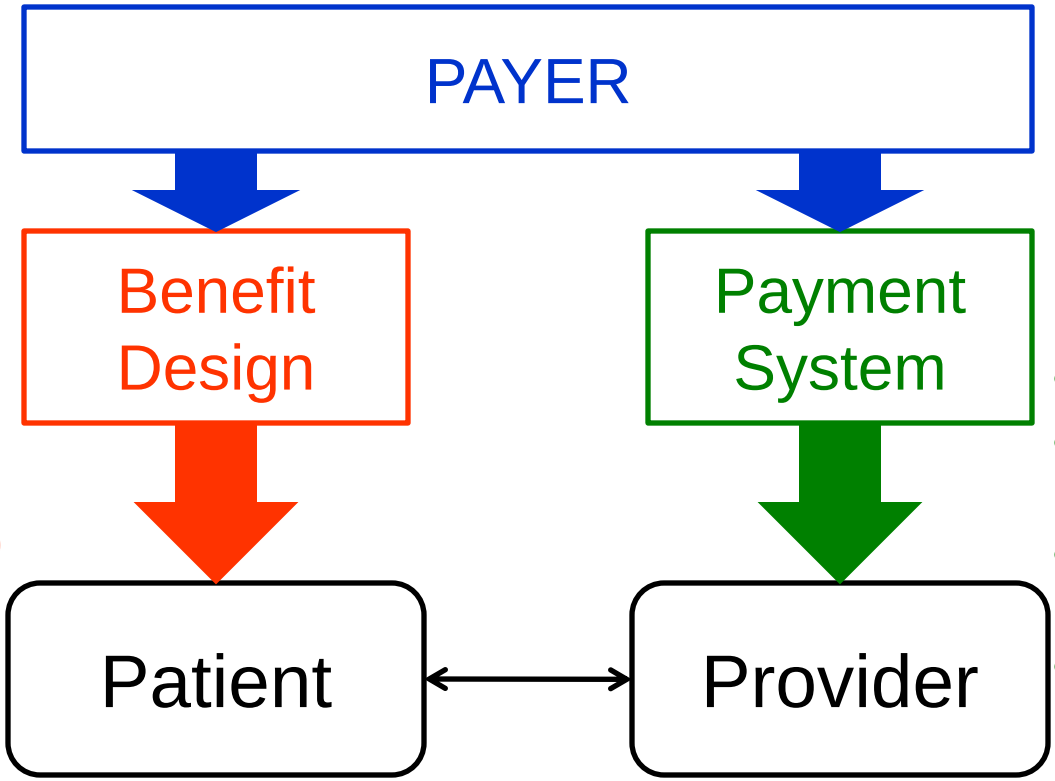
# Where Will You Get Your Knee Replaced?

**Knee Joint Replacement**



| Consumer Share of Surgery Cost | Price #1 $23,000 | Price #2 $28,000 | Price #3 $33,000 |
|---|---|---|---|
| $1,000 Copayment: | $1,000 | $1,000 | **$1,000** ✓ |
| 10% Coinsurance w/$2,000 OOP Max: | $2,000 | $2,000 | **$2,000** ✓ |
| $5,000 Deductible: | $5,000 | $5,000 | **$5,000** ✓ |
| Highest-Value: | **$0** ✓ | $5,000 | $10,000 |

# Both Payment & Benefits Are Controlled by the Payer



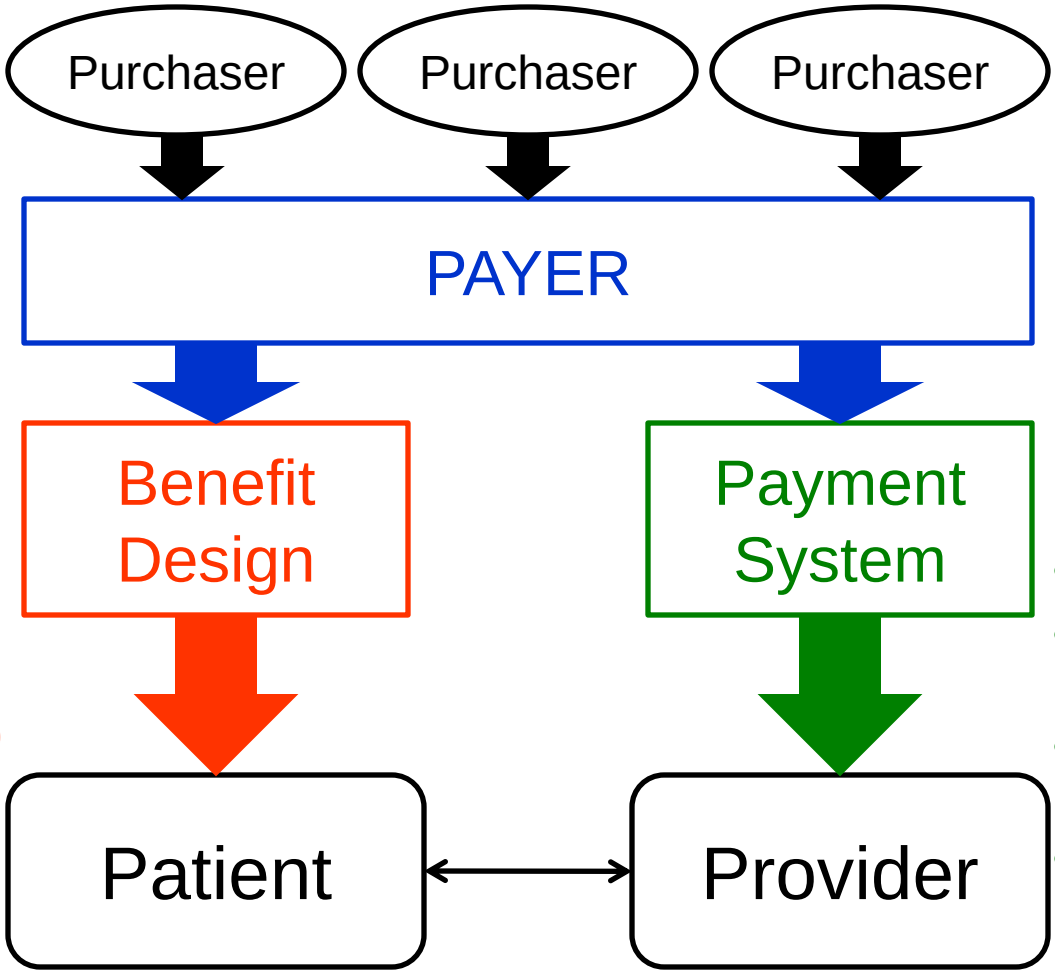

**Ability and Incentives to:**

- Improve health
- Take prescribed medications
- Allow a provider to coordinate care
- Choose the highest-value providers and services

**Ability and Incentives to:**

- Keep patients well
- Avoid unneeded services
- Deliver services efficiently
- Coordinate services with other providers

# But Purchaser Support is Needed Particularly for Benefit Changes

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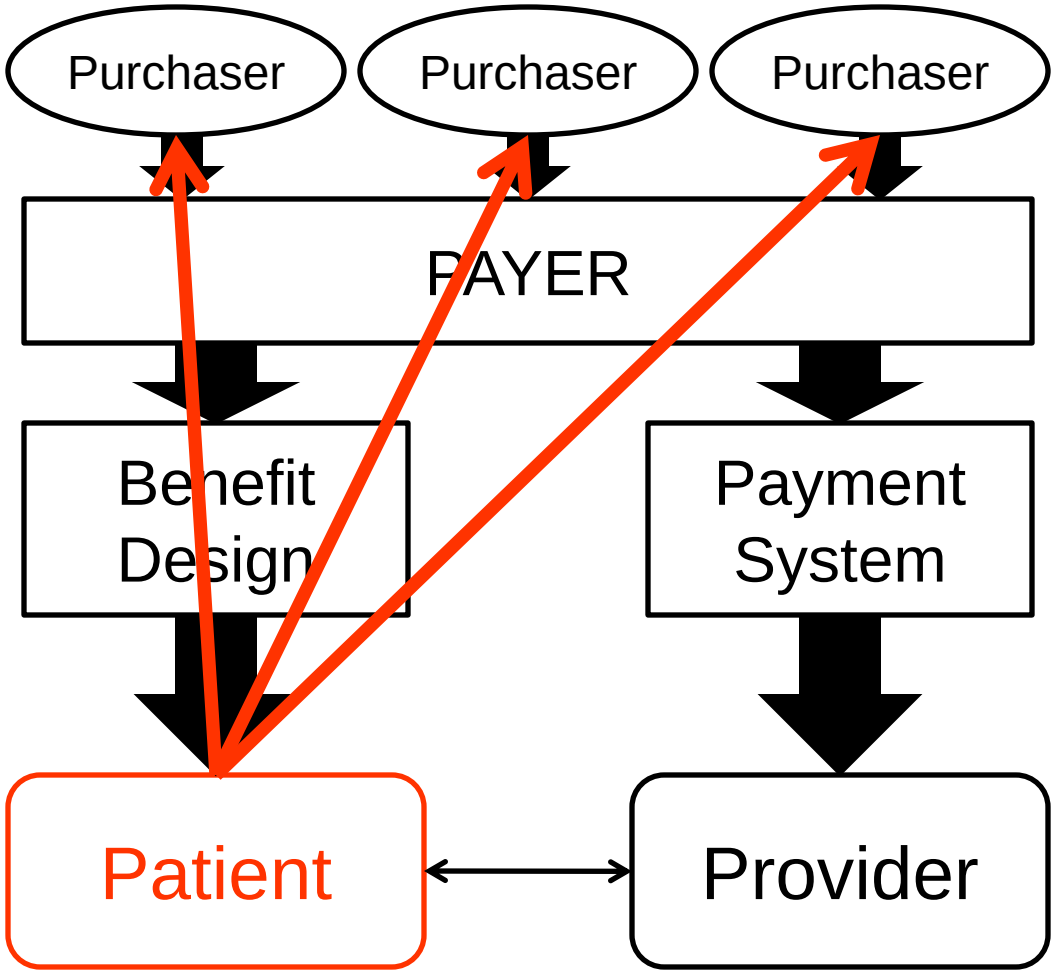
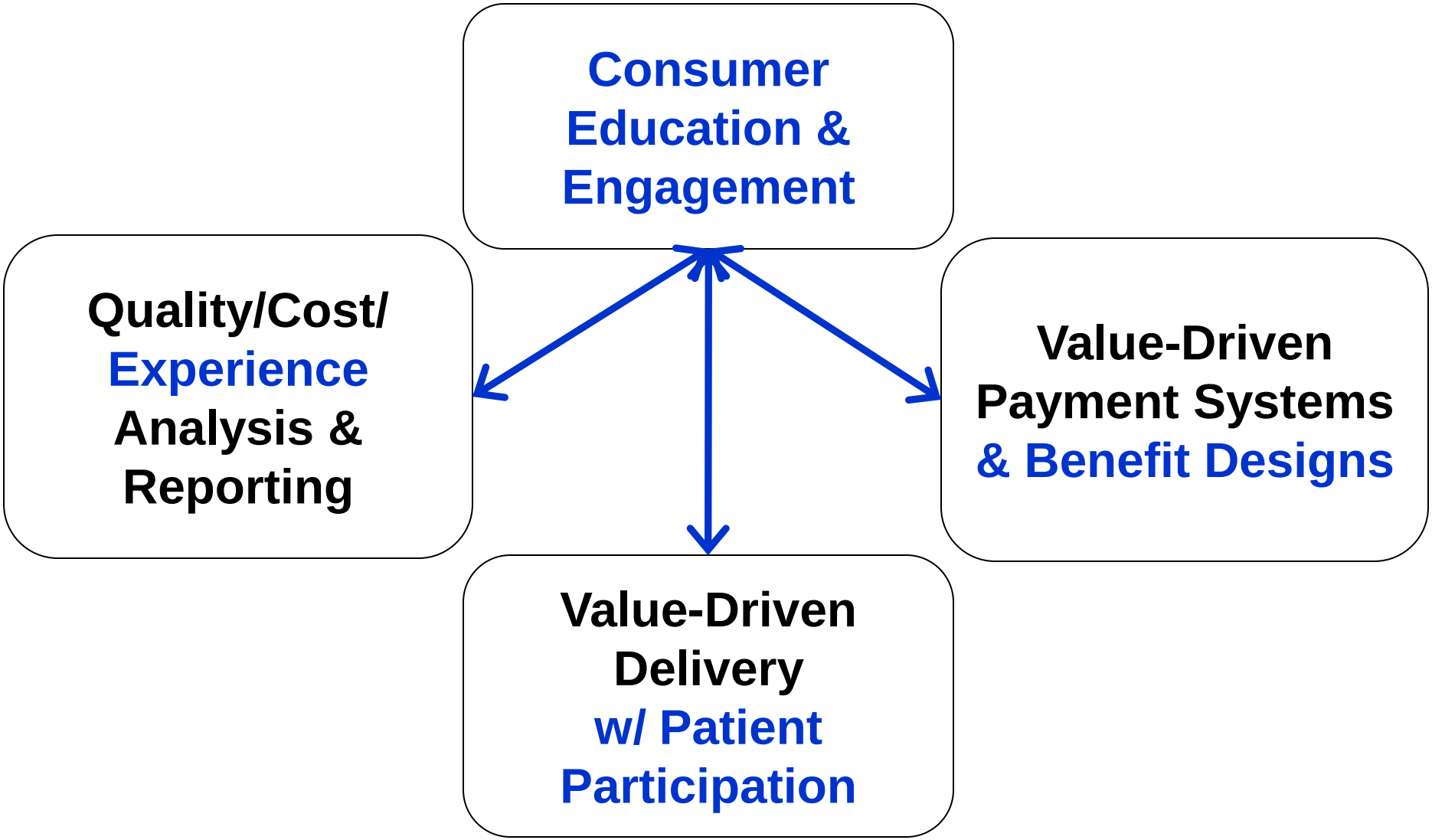
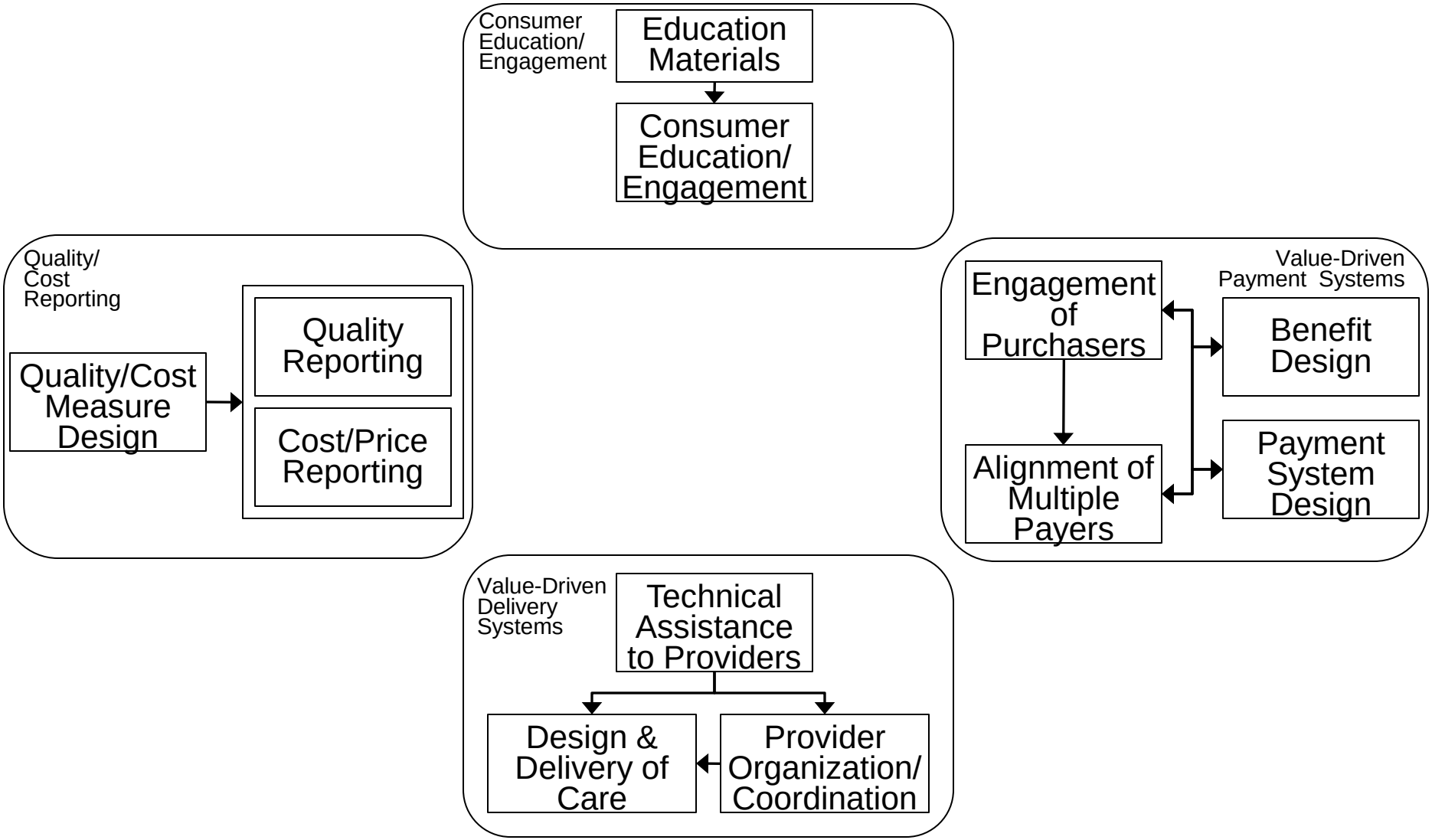
# And Consumer Support is Critical for Purchaser/Plan Support



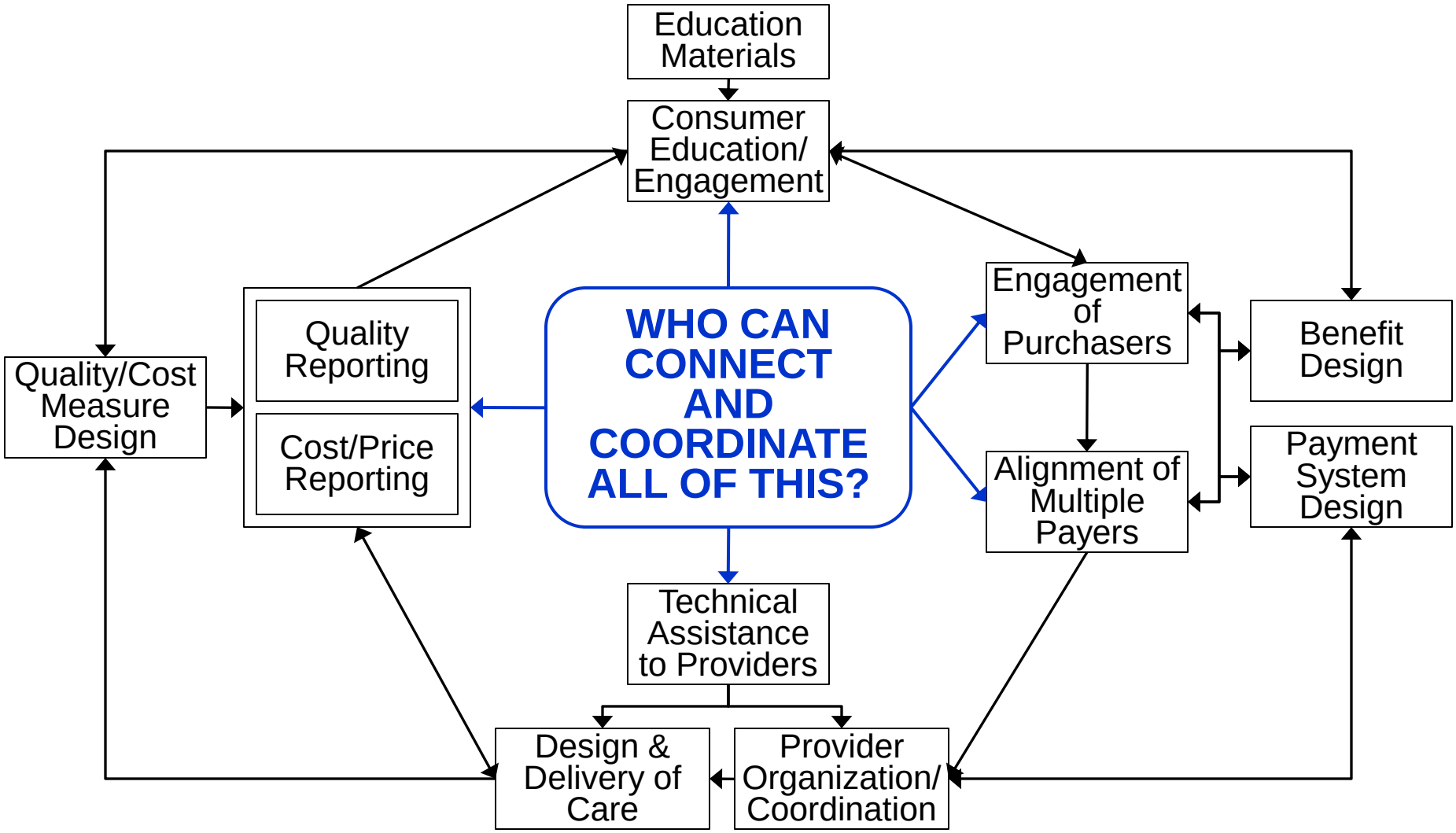
# Consumer Support is #4, And Fundamental to All



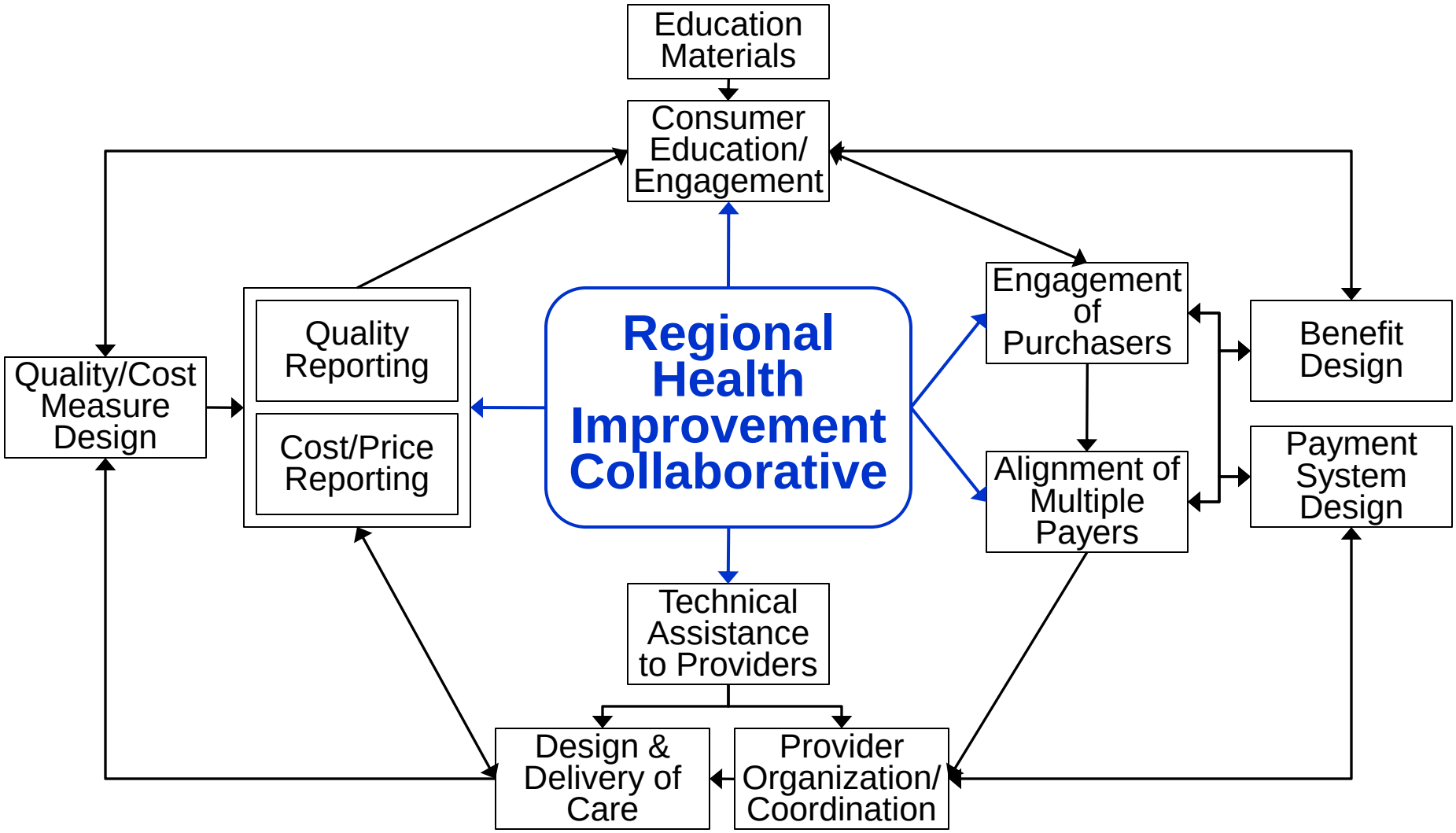
# Many Specific, Complex Tasks Within Each Function



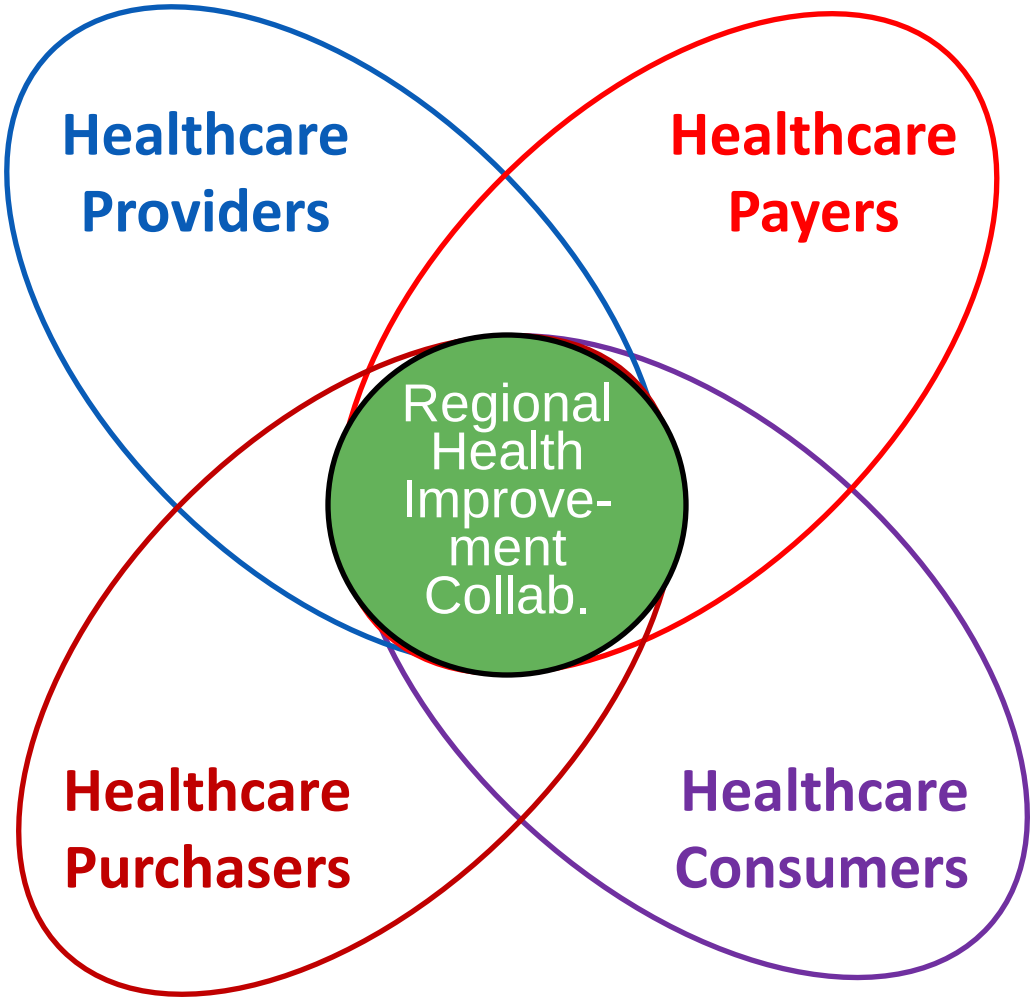
# Functions and Support Activities Can't Proceed In Silos



# That's the Role of Regional Health Improvement Collaboratives...

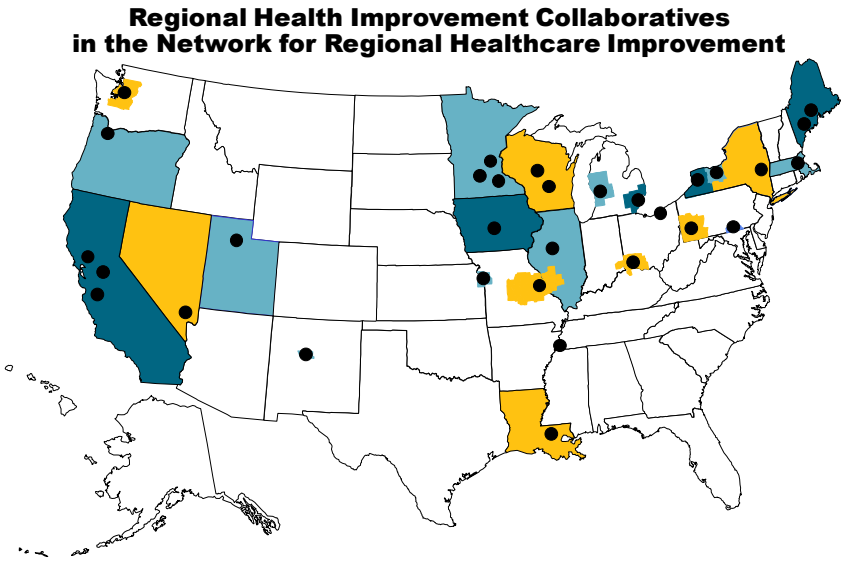


# ...With Active Involvement of All Healthcare Stakeholders



# Leading Health Improvement Collaboratives in the U.S.

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

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# Don’t Wait for Washington

- Recognize that there is no one-size-fits-all solution or implementation path; every state and community is different, and the best thing the federal government can do is to support local strategies
- Educate all stakeholders and build consensus on the need for changes in healthcare payment, delivery, and benefit structures to reduce costs and improve quality
- Convene stakeholders to design win-win-win approaches for their community and a feasible transition strategy
- Get federal and state support (e.g., Medicare, Medicaid, state employees, laws/regulations) for the community’s strategies
- Measure progress and resolve challenges through an ongoing state/local, multi-stakeholder, collaborative process

# For More Information:


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and
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www.CHQPR.org

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www.PaymentReform.org